

New York State Council on Graduate Medical Education



Policy Recommendations to the Commissioner of Health

March 2008

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Richard F. Daines, M.D.
Commissioner
NYS Department of Health
Corning Tower
The Governor Nelson A. Rockefeller
Empire State Plaza
Albany, New York 12237

Dear Commissioner Daines:

On behalf of the NYS Council on Graduate Medical Education, it is our privilege to provide you with the following report that outlines *Policy Recommendations to the Commissioner of Health*. This report that the Council developed over the past eight months comprises a series of recommendations relating to New York's Graduate Medical Education system. The Council was energized by the challenges that you requested for us to explore and eagerly took on the task without hesitation.

Since your presentation at the Council's Plenary Session on June 18, 2007, the Council divided into five workgroups, held numerous conference calls and deliberated in Plenary Session. The Council was greatly aided by several consultants who provided expert advice in formulating this report. In addition, Bureau of Health Economics staff (that now includes Council staff) and Executive staff in the Department of Health were instrumental in producing this report. We acknowledge the dedication, commitment and effort Council members and all of these individuals provided in the preparation of this report.

We hope the Department of Health will carefully consider these recommendations in future health care policies, such as in the current budget initiatives to provide Medicaid rate enhancements for physician and ambulatory care providers and in the *Doctors Across New York* initiative -- that were shaped based on the Council's deliberations and recommendations.

We are grateful to you for the opportunity, and confidence you have in the Council to formulate policy recommendations for New York's Graduate Medical Education system. We see this report and recommendations as a beginning dialog on needed and necessary policy reforms and look forward to working with you on additional details for any of the recommendations in the weeks and months ahead.

Sincerely,

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Background

The New York State Council on Graduate Medical Education was created by Executive Order in 1987 (and reauthorized most recently by Executive Order on January 1, 2007) to provide advice to the Governor and Commissioner of Health on the formulation and implementation of State policies relating to medical education and training. The Council is charged to consider:

1. Graduate medical education programs including the composition, supply and distribution of residency programs, subspecialty programs and fellowship training;
2. Efforts to increase the number of minority physicians in training in New York and to increase and improve the training of physicians who will serve as medical residents, and subsequently as practitioners, in underserved areas of the State and serve populations with special health needs;
3. The number and specialties of physicians needed in New York State;
4. Policies and programs to increase the training of primary care physicians and the training of physicians in non-hospital settings; and
5. Promotion of high quality residency and training programs.

Under the leadership of Drs. Alfred Gellhorn, Lambert King and John Naughton (its current Chairman) the Council has championed causes, including primary care education, increasing underrepresented minorities in medicine, and reducing resident work hours that have distinguished New York as a national leader in Graduate Medical Education (GME). In addition, the Council has provided leadership on residency training issues that include: cultural competence; biomedical research; and with developmental disabilities and special needs populations.

With policy direction from the Council, staff has administered a number of programs including: the GME Reform Incentive Pool; the Empire Clinical Research Investigators Program (ECRIP); the upweighting and Designated Priority Program (DPP); and grant programs in Minority Participation in Medical Education, Medical School Participation in Ambulatory Care and School-Based Health Centers, and Parent Partners in Health Education (PPHE). (See Appendix E for a summary of these programs)

The Council has participated with other organizations in sponsoring several conferences and events to increase educational opportunities in medicine for minorities and economically disadvantaged students along the academic pipeline and to promote training in primary care and ambulatory care settings. The Council was also instrumental in developing guidelines for the use of residents in Medicaid Managed Care Plans for both primary care and specialty residents in order to ensure that a single standard of care is provided to all patients regardless of payor.

The Council and has been recognized in the New York Prospective Hospital Reimbursement Methodology (NYPHRM), the Health Care Reform Act (HCRA) and the New York Code of Rules and Regulations (NYCRR – Title 10). The Council works through its four subcommittees: GME Reform; Primary Care and Workforce Development; Minority Participation in Medical Education; and the Steering Committee. In addition, the Council convenes ad-hoc committees, workshops and workgroups, as necessary.

The Council membership is broadly representative of health professional, hospital and public interests. Members are appointed by the Governor, upon recommendation of the Commissioner of Health. The Council consists of up to 30 members.

Preamble

In June 2007, the Commissioner turned to the Council for its advice regarding the current status of GME and for recommendations regarding reforms and improvements (see Appendix A for the full text of the Commissioner's remarks). While the work of the Council primarily focuses on GME, its charge can not be addressed in isolation of issues related to the escalating cost of health care, access to services, and physician workforce supply and distribution. Effecting change in these areas requires complementary action in arenas outside of GME such as malpractice reform, enriched educational opportunities throughout the educational pipeline and medical practice incentives.

The recommendations in this report stem from knowledge of New York's GME system of training, finance, and patient care delivery. Three to more than seven years of supervised graduate medical education is necessary to adequately prepare a physician for fully independent practice after receiving an M.D. or D.O. degree from medical school. In contrast to the focus of undergraduate medical education on general intellectual preparation and basic skills, graduate medical education emphasizes the acquisition of specialized knowledge and practical clinical and procedural skills relevant to selected specialties or subspecialties. The GME pipeline produces fully trained practitioners for all specialties, practice settings and regions. Formal GME is a pre-requisite for medical licensure, specialty board certification, and for virtually all payer and hospital physician credentialing.

Acute care "teaching hospitals" and their associated ambulatory care "clinics" have served as the principal locus of graduate medical education over the last four decades or more. Medical school graduates from across the nation and the world enroll in New York's postgraduate training programs. Teaching hospitals serve a diverse population of patients, provide high-tech services and facilities for specialized patient care, and offer attractive roles and support for teaching faculty. In addition, teaching hospitals integrate patient care with resident education and have evolved professional staffing models reflecting this arrangement.

Medicare, Medicaid and State hospital reimbursement policies have played an indispensable role in establishing and reinforcing the primacy of teaching hospitals in graduate medical education and patient care for elderly, impoverished, and uninsured populations. Legislation attached a GME label to these funds while

intending them for costs associated with operating a hospital in which education is delivered. Reliance on these federal and state funds associated with GME often increased in tandem with hospitals' increasing safety net role. Despite this support, growing challenges of covering hospital operating costs and meeting capital needs confront all hospitals in New York. Flagship medical school hospitals as well as small, often struggling, community hospitals primarily dedicated to safety net services, are therefore depending on GME support to fulfill their missions.

Health care delivery is in transition. Some of the original and newly emerging high tech services that made the acute care hospitals attractive for specialty education have migrated out of the hospital proper to ambulatory and free-standing centers. The service mix of most hospitals has evolved towards ever more highly specialized services or towards serving as an emergency, off-hours and social safety net for patients not well served anywhere else in the health care system. Patients in need of highly specialized surgical, medical, and emergent care compete for beds with those with less urgent needs, placing a strain on teaching hospitals, faculty, and residents. Simultaneously, availability and access to preventive care and ambulatory care for managing chronic illness is a problem for many patients.

Presently, relatively little resident training occurs in ambulatory settings where most preventive care and disease management needs to occur. Preparing a properly skilled physician workforce for the future requires an appropriate balance of inpatient and ambulatory education experiences. New York's investment in GME must be guided by this principle and the imperatives of sustaining and enhancing quality in medical education and research, replenishing the physician workforce, and distributing physicians to regions where they are needed.

Seventy-five percent of physicians practicing in New York State trained at one of its teaching hospitals or major medical centers. Despite this fact, the physician supply is increasingly maldistributed with rural, upstate and underserved urban areas reporting growing shortages. Shortages were first apparent in primary care fields but there is increasing awareness that shortfalls will be felt in many previously well-supplied procedural and cognitive specialties. The Council and the Department of Health has responded to the maldistribution by endorsing and supporting the establishment of Area Health Education Centers (AHEC), in conjunction with the Associated Medical Schools of New York. This program established centers in underserved and rural areas that serve as an entrée into health

professions for residents of these communities. As the nationwide doctor gap grows, New York's problems will only worsen without further investment in programs such as AHEC and those emphasizing primary and preventive care and disease management.

Against this backdrop, New York GME reform is a necessity. The Commissioner of Health asked the Council to consider and incorporate the following principles:

- New York should retain a leadership role in GME, emphasizing and supporting the strongest elements of its current configuration while being open to change in the directions of increased emphasis on training in ambulatory settings, primary and preventive care and attention to underserved populations and health care disparities.
- It is recognized that GME financing in New York has evolved to underwrite a number of historically valid but not directly (or in some instances not even indirectly) GME-related public goods and services, particularly with regards to mid-level professional staffing and the safety net function of teaching hospitals. It is also recognized that GME funding has become so essential to many hospitals as to make it difficult for them to reconsider their teaching status and teaching scale unless alternative staffing and funding mechanisms are developed.
- While recognizing the importance of an orderly and phased transition, New York should begin the process of shifting its support of GME into settings that reflect the changing face of health care. Efforts should be given to re-labeling and re-directing public funds for the direct support of public goods and ambulatory care services rather than through the current system that indirectly channels public dollars designated as GME for these purposes.
- Issues of the supply and distribution of practicing physicians will require increased direct attention to reimbursement, professional satisfaction and lifestyle factors affecting the practicing workforce and largely out of the reach of GME policy itself. Redirecting the supply pipeline to rural and other underserved areas may benefit more from the selection and grooming of undergraduate medical students than from major investments in residency training.

- Leadership in biomedical research and elevation of standards of clinical care must be pursued on broader foundations than GME alone.

Recommendations

To address the Commissioner's request, the Council proposes a series of recommendations for New York's GME system. Those noted with a star were ranked among the highest by the Council.

Transparency and Accountability in GME

- ★ Institutional GME Budget - Require an annual GME budget be jointly prepared by entities receiving GME payments and their sponsoring institution. This budget should treat the direct portion of GME as a product line identifying expenditures and explicitly identified revenues including Medicaid, Medicare, the Professional Education Pool and funds negotiated with private payers. Institutions must also report those revenues explicitly identified as indirect medical education funding which are intended to support those additional costs associated with operations in a teaching setting. The sponsoring institution's Designated Institutional Official (DIO) will prepare and submit an annual report to the NYS Department of Health, sponsoring institution leadership, and residency program directors.

- GME Reallocation –

Use of GME-label - Remove the GME-label from those Medicaid funds assigned to non-teaching hospital-based physicians.

Analysis of Current Medicaid Payments - A full analysis of Medicaid payments must be completed prior to additional re-labeling of payments currently categorized as Direct and Indirect GME. This analysis should consider all inpatient care costs incurred by hospitals, including those related to GME, as well as total payments, including those with a GME label. Upon completion, Medicaid payments with a GME label that are not subsidizing GME program requirements should be directed for eligible Medicaid patient care services in appropriate ambulatory and inpatient settings. By so doing, Medicaid continues to recognize legitimate costs of providing services to Medicaid patients.

- Ambulatory Training - Develop and implement a funding mechanism to support training opportunities for GME residents in ambulatory sites. Such settings should be committed to education and demonstrate success in promoting high quality continuity of care that is effective, efficient, safe, timely, patient-centered and equitable. Funding should flow to the entities that incur the cost of training, including hospital and cost efficient free-standing ambulatory sites, to the extent GME inpatient funding is currently cross-subsidizing outpatient care. Disincentives for hospitals to place residents in these sites should be minimized.
- Enhanced Upweighting - Provide enhanced upweighting for primary care programs targeting funds for faculty to mentor residents in primary care. Funds will free-up faculty from current patient care responsibilities and should be included in the annual GME budget.
- ★ Incentive/Innovations Pool - Enhance the amount of funding dedicated to the GME Reform Incentive Pool in order to influence GME policy changes in teaching hospitals. Such reforms should encourage innovations to stimulate new and novel approaches to enrich teaching and address quality of care, physician supply, training and teaching in biomedical research (i.e. ECRIP), cultural competence and diversity in medicine. New funding should be invested to address these GME policy initiatives and programs should be encouraged to share successful strategies with other programs and institutions.
- Replacement Demonstration Project - Design and implement a voluntary demonstration project with long term funding to assist and sustain hospitals seeking to significantly downsize teaching programs or transition from a teaching to non-teaching facility.
- ★ Regional Collaboration - Develop and implement collaborative regional education programs to address the State goal of increasing physician training and access to health care services in rural and inner-city underserved communities and to serve minority and economically disadvantaged populations. GME consortia or other community planning organizations will develop strategic plans and pool resources to provide programmatic and financing alternatives that include innovative uses of GME and other health care funding resources.

Quality of GME

- ★ Standard of Care - Ensure a single standard of quality care for patients regardless of their socioeconomic or insurance status. This system should be based on the Council's guidelines adopted for Medicaid Managed Care plans and include provisions for verification.
- Peer Review - Develop and implement a new system to improve the quality of residency training programs through a peer-review process. This system would supplement current accreditation standards through the use of triggers (i.e. cycle length, accreditation status, hospital patient care indicators) to identify low-performing programs in order to assist such programs to improve quality of teaching and patient care. This system should make full use of opportunities to work within the existing accreditation process prior to considering any independent or formal role.

Physician Supply

- ★ Practice in Underserved Areas – Fund a new educational loan repayment program with a service obligation to encourage new primary care and specialty physicians and dentists to practice in rural and inner-city underserved communities. In addition, provide funding to allow new physicians, including primary care and specialists, to establish practices in rural and inner-city underserved communities. Such funding could be part of a recruitment incentive package.
- Training in Underserved Areas - Create tracks for a limited number of existing primary care residents and subspecialty fellowship positions (that are in high demand) that will require these physicians to practice in rural or inner-city underserved communities after program completion. Financial incentives (i.e. loan repayment and practice support) that encourage practice in underserved communities will be provided for program graduates.
- Clinical Training Experiences - Develop clinical training opportunities for medical students and residents that reflect the geographic, demographic, culture and health needs of the population with appropriately experienced

medical professionals. These issues should include: cultural, linguistic and ethnic diversity; disease characteristics of the population; and health needs for the elderly, disabled and special needs populations and rural residents, which are modeled after successful programs in New York and nationally.

- Practice Environment - Improve the physician practice environment in New York State to attract and retain physicians through reforms in:
- ★ Medical Malpractice - Support medical liability reforms to reduce the high cost of medical malpractice insurance.

Administrative Costs – Develop models for payors to reduce administrative complexities in order to minimize the cost of medical practice.
- ★ Reimbursement - Adopt reimbursement reform that provide enhanced reimbursement for physicians based on the time commitment to provide primary and cognitive care services rather than the current procedure-oriented reimbursement system.
- Physician Retraining – Encourage the development of programs that retrain physicians in clinical skills necessary to re-enter clinical practice.
- J-1 Visa Waiver - Petition the federal government to increase the number of J-1 Visa waivers relative to a state's population to allow for additional International Medical Graduates to remain in the U.S. and serve in underserved areas.
- Long Term Strategy - Provided the aforementioned strategies do not meet the physician supply needs, other initiatives should be considered, such as: expanding GME positions in certain underserved regions or specialties; providing support to communities or providers to sponsor H-1 Visa International Medical Graduates to practice in underserved areas; and expanding the use of non-physician clinical providers.

Cultural Competence & Diversity in Medicine

- Academic Pipeline - Provide funding support to new or successful programs that expose minority and economically disadvantaged students along the

academic pipeline (from elementary school settings through practice) to educational opportunities that can lead to careers in medicine and the health professions. Pipeline programs should include work with guidance counselors and others who influence career choices for students, in cooperation with the State Education Department.

- Cultural Competence - Increase the number of teaching facilities that provide eight hours of cultural competency training for a minimum of 80 percent of residents as defined in the GME Reform Incentive Pool. This initiative should include an evaluation component to measure the impact on residency competence and professionalism. In addition, develop a standardized Continuing Medical Education (CME) course in cultural competency and foreign language proficiency that integrates the use of interpretive language services.
- Second Language Proficiency - Encourage appropriate national accreditation bodies that govern medical school admission requirements to adopt pre-admission requirements that promote cultural competence such as proficiency in a modern non-English language.

Biomedical Research

- Invest in Biomedical Research - Provide significant financial investment in the arena of biomedical research (similar to New York's support for nanotechnology) to enhance and provide a robust industry to draw researchers, research entities and funding to New York.

Data Collection

- Data Collection - Support and sustain a statewide data collection system that provides periodic information and analysis of the current and future physician workforce. Rapid assessment of data is necessary in the following areas:
- ★ Physician Supply and Needs - These should include physician supply forecasting and community surveys to predict physician need and demand.

At-Risk Medical Specialties - Studies should also look at potential intermediate and long-term access issues for specialties. Mechanisms to rapidly address these crises should be established so that there are enough qualified physicians practicing in these specialties to prevent access emergencies. Obstetrics is one example of a specialty currently at risk.

Capacity of Residency Programs – Basic to understanding future physician demand is an understanding of current residency program capacity by specialty. The resulting data would be useful to both teaching institutions to reconfigure residency positions toward other needed specialties and the State in its reimbursement of GME.

State by State Comparison - Contributions made to GME from all funding sources for comparison of New York State GME expenditures with other states. This study should include sources of funding used to support teaching and biomedical research.

Transparency and Accountability in GME

I. Background

The annual cost of training nearly 16,500 residents in New York State is \$3.4 billion. Some have raised concern that the investment is not yielding the results the State deserves. The Commissioner noted the “reliance on GME programs and reimbursement as the best or perhaps only means of achieving certain public goods (e.g. including indigent care, physician recruitment and retention, and medical research). Funding channeled through Graduate Medical Education (GME) has come to be regarded as a general and essential hospital revenue stream rather than as a proper payment for the proper costs and value of GME itself. Commingling of GME labeled funds for education and other hospital missions creates a dependence on maintaining resident education programs in lower quality training environments.”

Dr. Daines suggests a more rational system would align funds with their intended purpose. “GME should be sized, configured and reimbursed around its core mission – attracting, training and launching into New York the physicians needed to serve our citizens and support some New York institutions as clinical and biomedical research leaders.”

New York is not alone in raising questions about GME. A regulation to eliminate Federal Medicaid matching payments for GME would adversely affect the ability of New York teaching hospitals to meet their education, research, and patient care missions. A one year moratorium on this regulation was enacted by Congress and will expire on May 28, 2008. Allowing this regulation to be implemented by the Centers for Medicare and Medicaid Services (CMS) would compound demands on state budgets, particularly for New York since one-third of the nation’s Medicaid GME is spent in NYS.¹ These demands and the “unrealistic expectations for GME do not necessarily favor continuation of the GME status quo,” according to Dr. Daines.

II. Charge

The Council was charged to examine New York’s complex GME funding streams

and respond to the following questions:

1. What costs are currently reimbursed by New York State through GME funding?
2. What other hospital activities are subsidized with GME payments?
3. What costs should appropriately be considered GME and reimbursed accordingly?
4. How does New York State's payment methodology and levels compare to Medicare and other states?
5. What factors contribute to the variability of payments

The Council identified the following two supplemental questions:

6. What costs are associated with establishing and maintaining an ideal ambulatory resident training environment?
7. How can the investments in New York's HCRA and GME Reform Incentive Pool most effectively yield outcomes in the interest of New Yorkers?

III. Discussion

The Council focused on examining and elucidating New York's complex GME reimbursement mechanisms, on identifying the purpose and use of GME payments, and recommending adjustments that would align purpose with payment and support New York's mission to improve access and quality of healthcare. The Council is mindful of the contributions and obligations of hospitals to both GME and patient care. It therefore undertook the assignment with the goal of enhancing the quality of resident training without compromising New Yorkers' access to health services. A vision for change was balanced with a concern for the pragmatic steps that would need to occur to avoid a chaotic transition. What follows are responses to the specific questions and comments on related issues identified in the course of deliberations.

Activities Subsidized with GME Payments

Contributions from Medicaid, Medicare, and private insurance programs, as well as the Veterans Administration collectively support GME. In some cases, these are supplemented by contributions from other sources such as medical schools, hospitals, and faculty practices. New York State reimburses hospitals with funds carrying a GME label for costs associated with patient care delivery as well as teaching. Historically, payments recognize additional costs associated with care in teaching hospitals. Governmental and private payers bore these additional costs because of the enhanced quality and quantity of care provided in settings with residents and teaching faculty. While some of these payments are traceable to direct costs associated with teaching, others are embedded in payment formulas, making it impossible to link the funds to a specific purpose.

Medicare

Medicare GME is a Federally funded program that provides approximately \$1.7 billion annually in payments to New York.

Direct GME (DGME) costs are identified on a hospital's annual audited cost report. They include the hospital's expenses for teaching faculty and resident compensation and allocated overhead. The payments are paid periodically to hospitals in a lump sum. In 2004, Medicare DGME aggregate payments in New York amounted to \$623 million.

The Medicare DGME payment formula is based on three variables: an allowable cost per resident (Per Resident Amount, or PRA) based upon 1984 costs and updated for inflation each year; an annual count of full time equivalent (FTE) residents representing the number of individuals actually training in the facility and its affiliated ambulatory; the proportion of inpatient days provided to Medicare patients. These three variables are multiplied to derive Medicare's DGME payment.

$\begin{aligned} & (\text{Hospital per resident amount (PRA)} \times \text{Consumer Price Index}) \times \\ & (\text{Number of FTE residents}) \times (\text{Medicare inpatient days/total inpatient days}) \\ & = \text{Medicare DGME payment} \end{aligned}$
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Indirect Medical Education (IME) is a patient care adjustment to teaching hospitals' Diagnosis-related groups (DRG) payment. The IME adjustment was

created because it was observed that even after all of the other features of the payment system were applied, teaching hospitals continued to have higher costs that were not captured by the payment system. These higher teaching hospital patient care costs include longer treatment times, increased testing associated with training residents, more severely ill patients within a particular DRG, additional costs associated with maintaining trauma, emergency and specialized services, and research associated with clinical care and treatment.

The level of the IME adjustment is not attributable to GME activities. Rather, the adjustment is derived through regression analysis of hospitals' Medicare costs, *excluding* DGME. The calculation is based on the ratio of interns/residents to beds (IRB) and an adjustment factor that has varied from 8.1 percent to its current level of 5.5 percent. In 2004, Medicare IME aggregate payments to New York were approximately \$1.1 billion.

Medicaid

Medicaid supports GME through a joint Federal-State program. Federal law requires compliance with certain minimum requirements but allows States considerable leeway in designing the specifics of their programs. GME payments are made through fee-for-service rates as well as separately for Medicaid managed care services.

Medicaid Direct GME is similar to Medicare's, except that it also includes costs associated with "hospital-based physicians," who are neither residents nor teaching physicians. Because any hospital may employ physicians, not just teaching hospitals, many non-teaching hospitals in the State receive Medicaid payments with a DGME label.

For the most part, all Medicaid costs are derived from a 1981 base year, including an identified GME portion. Medicaid applies formulas to determine the costs attributed to GME and those attributed to non-GME operating costs. If one portion increases, the other decreases. As noted, by statute, Medicaid includes all hospital employed physicians in the GME-labeled portion.

Medicaid does not recognize the costs of hospital clinic, ambulatory, or off-site training in identifying the DGME portion of the rate. In 2006 Medicaid payments for Direct GME were approximately \$540 million.

Medicaid Indirect Medical Education

Medicaid applies the Medicare formula for IME with unique definitions for residents and beds in the IRB ratio. Medicaid's formula uses the number of residents in training in 1990 as the numerator and number of beds in hospital in 1990 as the denominator. A 7.7 percent IME adjustment factor is applied to this IRB.

Medicaid develops a group average payment rate for all hospitals in a peer group with similar characteristics (e.g., academic medical centers, major teaching hospitals, non-teaching hospitals, etc.). The IME is carved out of the hospital's rate and added back after adjusting the resident count in accordance with a weighting system, ranging from 0.9 FTE – 1.5 FTE, designed to meet New York State's workforce goals. The highest weight is assigned to residents in primary care training programs identified as "Designated Priority Programs" by the Department of Health, upon recommendation of the Council, through an application process involving peer review. Residents training in ambulatory settings are included in the calculations. In 2006, approximately \$810 million were labeled Medicaid IME.

Health Care Reform Act Professional Education (GME) Pool

The Health Care Reform Act (HCRA) created the Professional Education Pool (PEP) in 1996 to guarantee continued support for GME from private health insurers after the dissolution of rate-setting. The pool is funded by a tax on health plan insured lives. Approximately 10 percent of the pool is carved out as the "GME Reform Incentive Pool" to influence achievement of the State's GME goals. The pool, originally funded at \$54 million, was reduced to \$31 million. Goals and reform objectives are established in consultation with the Council. Current objectives are:

- Reducing the number of non-Designated Priority Programs (i.e. subspecialty programs) and residents training in such programs
- Increasing the proportion of residents training in ambulatory care sites
- Increasing the proportion of residents training in ambulatory sites that are located in underserved communities or care for underserved populations
- Increasing the number of underrepresented minority residents
- Increasing minority faculty in teaching hospitals
- Building the academic pipeline for minority students
- Increasing cultural competence training

- Promoting biomedical research through the Empire Clinical Research Investigator Program (ECRIP)

Costs Appropriately Subsidized with GME Payments

GME payments should subsidize costs associated with training requirements established by the appropriate accrediting body. The Council believes that financial incentives should continue as a mechanism for encouraging innovative programs and training objectives that meet statewide goals. Additional State funding should be invested to support these GME transitions.

Uncoupling direct and indirect reimbursements under the assumption that the former are intended as educational subsidies would be inadequate. The currently designated “Direct” costs are too narrowly defined or have not kept pace with costs in today’s market (e.g. resident, program director, and program coordinator salaries, training exam fees, registration fees for required conferences). Costs associated with delivering care are increasingly included in accreditation requirements. Therefore it is reasonable to include a portion of these costs, currently embedded in the IME-label, in the GME subsidy. An essential prerequisite to a wholesale relabeling exercise, however, is a careful analysis of funding streams to determine the impact on essential patient services.

For example, the Accreditation Council on Graduate Medical Education (ACGME) Family Medicine requirements mandate that ambulatory care sites include items currently embedded in GME payments:

- (1) There must be a reception area, waiting room and business office that are consistent with the patient care and educational needs of the residency.
- (2) A suitable resident work space and a separate private area for resident precepting, as well as an office library resource must be included. Computer access to electronic resources must be readily available for all of the physicians practicing in the Family Medical Center (FMC).
- (3) Two examining rooms that are large enough to accommodate the teaching and patient care activities of the program must be available for each physician faculty member and resident when they are providing patient care. Additional space for individual and small group counseling must be included.

(4) Faculty offices, if not in the FMC, must be immediately adjacent to the Center.

(5) The program must have a conference room that is conveniently accessible and readily available, as needed, and that is large enough to accommodate the full program. In programs using multiple FMCs, there must be a meeting room within or immediately adjacent to each FMC that is large enough for smaller meetings of all faculty, residents, and staff who work at that site.

(6) Programs not using an electronic medical record system should document their plans for conversion to one in the near future.

(7) The fiscal operation of the Family Medicine Center must reflect an appropriate balance between education and service. Service demands must not adversely affect the educational objectives. A plan should be in place to ensure fiscal stability of the program.²

Costs associated with hospital-based training are identified in ACGME requirements for institutions sponsoring Graduate Medical Education programs. Hospital's must provide:

- Laboratory facilities
- Imaging facilities/diagnostic radiology
- Chart, dictation and record keeping
- Resident access to computers
- IV support
- Phlebotomy support
- Patient transport
- Transport for specimens, radiographs, etc.
- Nursing support
- Clerical support for patient care
- Access to reference material in print or electronic format
- On Call Rooms
- Access to adequate food service 24 hours daily
- Provisions for Safety on hospital grounds, including parking facilities³

A reliable salary source for program director, faculty, and residency coordinator salaries is essential for sustaining high quality programs. “Clinical teachers have been under intensifying pressure to increase their clinical productivity — that is, to

generate revenues by providing care for paying patients. As a result, they have less time available for teaching, often to their immense frustration. In addition, the harsh, commercial atmosphere of the marketplace has permeated many academic medical centers.”⁴

Since 1997, the GME Reform Incentive Pool has been an important vehicle for promoting State policy objectives that have been identified by the Council. However, the current allocation for these objectives is a limited amount relative to the total amount of funds dedicated to GME. The impact of the \$31 million is diluted by required distributions for all eight objectives in each of the eight NYPHRM regions among 100 teaching hospitals. As a result, Incentive Pool funds are insufficient to influence GME reform, provide no flexibility to encourage targeted innovations, and are spread too thin across the State.

Over the past two years, the Council has focused on evaluating Incentive Pool trends and current objectives. Declining performance has been noted in awards for the Cultural Competence training objective (65 awardees in 2001 to 24 awardees in 2006) and the total number of residents training in ambulatory care sites has declined by two percent in the last two years. The Council’s GME Reform Subcommittee has discussed eliminating objectives that have not been achieved as well as consolidating or substituting others to better meet current policy goals. Training in patient safety, quality improvement, and information technology have been considered as possible new objectives.

Comparison of New York State’s Methodology to Medicare and Other States

It is believed that New York’s GME programs receive substantially higher reimbursements than programs in other states. The Governor expressed concern at the discrepancy in Medicaid funding between California’s per resident expenditures of \$21,000 and those of New York at an average of \$77,000 per resident. An analysis was undertaken to assess the validity of the comparison.

In July 2007, the Council developed a survey to determine the sources and methods states use to support GME. At the request of the Department of Health, this survey was distributed to all states by the National Association of State Medicaid Directors to identify “which states fund GME through Medicaid, which fund [GME] through other means, the rationale for doing or not doing so, and

funding formulas and language.”⁵ Of the twenty-four states that responded to the survey, twenty-one reported some form of reimbursement for GME and three reported no funding for GME (see Appendix B). Fifteen states provided total state funding for GME that included Medicaid payment data for GME for different fiscal years and six states did not provide any Medicaid payment data.

The analysis of the data, along with NYS GME data, showed that States use a combination of methods to fund and reimburse GME costs to teaching hospitals. These include Medicaid funding based on Medicaid revenue patient volume, resident count, legislative appropriations, tobacco tax revenue, managed care rate carve-outs, general funds, lump sum distributions and Medicare methodology. The data demonstrates that: (1) Medicaid expenditures is only one part of the GME funding; (2) these funds are administered quite differently across the country; and (3) states use a variety of other mechanisms for funding GME. Therefore, state to state comparisons of Medicaid per resident expenditure may be misleading. Accurate comparisons require supplemental surveys to identify all additional funding streams.

Factors that Contribute to the Variability of Payments

Hospital payments under Medicare vary in accordance with hospital specific direct costs identified in 1984, the number of FTE residents rotating in the hospital and its affiliated ambulatory sites, and the percent of Medicare inpatient days. Historical employment arrangements for faculty and residents (e.g. costs borne by hospitals or shared with medical schools, practice groups or other entities), prevailing wages in a community, and accuracy of claimable costs reported in 1984, all factor into the wide variations in the per resident amount among institutions in New York State.

Below are some examples of these variations:

- State university hospitals may have *lower* costs because the State, not the hospitals, pay for supervising physician costs.
- Private university hospitals may have *lower* costs because their affiliated medical schools, not the hospitals, pay for faculty.
- Freestanding academic medical centers or teaching hospitals may have *higher* costs because they bear 100 percent of resident and faculty costs.
- Teaching hospitals in communities with more privately insured patients

might have *lower* costs because faculty with private practice billing opportunities can volunteer their time.

- Teaching hospitals in poorer communities where patients are uninsured or insured by Medicaid may incur *higher* costs because they must fully salary their faculty, who lack private practice income opportunities.

For all these reasons, DGME costs are not comparable among hospitals, which is why DGME payments were not averaged into the general hospital reimbursement rate and instead are paid separately on a hospital-specific basis.

Medicare locked in the cost variation that existed among teaching hospitals in 1984 by establishing each hospital's Per Resident Amount (PRA) from its costs in that year. In 1999, a PRA floor was established such that no hospital can now receive less than 85 percent of the national average PRA. Further, while hospitals with PRAs below 140 percent of the national average PRA receive regular inflation updates to their PRAs, those institutions with PRAs above 140 percent of the national average are not entitled to any adjustments for inflation.

Additional variation is explained by modifications in the methods for counting residents. The FTE resident count is adjusted based on whether residents are enrolled in their initial program leading to Board eligibility. Medicare also froze the per resident amount in 1994 and 1995 for non-primary care specialty residents, limited the number of each hospital's reimbursable FTE's to the 1996 level, and introduced a provision permitting hospitals to annually form affiliations for the purpose of aggregating their respective caps. Hospitals are also permitted to claim reimbursement for residents training in non-hospital settings if the hospital documents that it incurs the costs of training.

The variability in IME payments under Medicare is dictated by the number of resident FTEs (without penalty for training beyond the initial residency period) and hospital beds. Since the payments are rate adjustments and not paid in a lump sum, they are not retrievable through auditing a schedule on a cost report.

Variability in Medicaid payments, as with Medicare, is partly attributed to costs reported in the 1981 Medicaid base year. These costs are updated for inflation as determined by the annual State budget process. Another source of variation is due to the system of assigning hospitals to peer groups (e.g., academic medical centers, major teaching hospitals, non-teaching hospitals, etc.) and establishing payments

based on average group costs. Finally, Medicaid IME is carved out of the group average, adjusted in accordance with the mixture of residents with some categories weighted more than others, and then added back to the IME. Therefore, two hospitals with the same raw number of resident FTEs might have different resident counts for purposes of the IME calculation due to the weighting process. This alters the amount received under Medicaid IME.

Unlike Medicare, Medicaid includes costs associated with employed “hospital-based physicians,” who are neither residents nor teaching physicians. Therefore, many non-teaching hospitals in the State receive Medicaid payments with a DGME label.

HCRA pool payments vary in accordance with the percentage of the pool generated by each hospital’s private payers.

Payment Variations

Medicare	Medicaid	HCRA
Base year supervisor salaries - 1984	Base year supervisor salaries - 1981	% of pool generate by hospital’s private payers
% salary incurred by teaching hospital	Payments for hospital based physicians in non-teaching hospitals	
Cost of living as reflected in salaries	Peer group averages	
Private Practice opportunities	Weighting resident counts in IME calculation	
% Medicare Inpatients		
Resident/bed ratio	Resident/bed ratio	

Principles/Observations

As the Council developed recommendations for transparency and accountability in GME, the following principles were identified:

- GME Payment reform should result in enhanced quality of resident education in New York State.

- GME payment reform should improve access to and quality of patient care for New Yorkers.
- Costs associated with patient care and resident education must be accounted for in any process that re-labels payments in the name of transparency.
- Hospitals should be afforded the opportunity to meet their patient care missions through a variety of methods.
- GME programs must prepare residents for a model of care that is safe, clinically sound, current, cost effective, and responsive to the needs of patients, families and communities.
- Direct costs associated with residency training have and will continue to increase as the ACGME outcomes-based training requirements are fully developed and implemented.

¹ Henderson, Tim. "Direct and Indirect Graduate Medical Education Payments By State Medicaid Programs." Association of American Medical Colleges. November 2006.

² Accreditation Council on Graduate Medical Education. Residency Review Committee. Family Medicine Program Requirements. Accessed Feb.22, 2008 [http:// www.acgme.org/acWebsite/navPages/nav_120.asp](http://www.acgme.org/acWebsite/navPages/nav_120.asp).

³ Accreditation Council on Graduate Medical Education. Residency Institutional Requirements. Accessed Feb.22, 2008 [http:// www.acgme.org/acWebsite/irc/irc_IRCpr07012007.pdf](http://www.acgme.org/acWebsite/irc/irc_IRCpr07012007.pdf). .

⁴ M.Cooke, M.D., D. M. Irby, Ph.D. "American Medical Education 100 Years after the Flexner Report". *NEJM*. 2006; 355:1339-1344

⁵ "National Association of State Medicaid Directors Survey, Graduate Medical Education: Select State Medicaid Payment Policies." American Public Human Services Association. August 9, 2007.

Quality of Graduate Medical Education

I. Background

New York spends far more than any other state on GME. This level of funding, however, does not insure an ideal learning environment. Difficult working conditions, poor continuity, and systemic inefficiencies, make it challenging to provide compassionate, culturally competent, patient-centered care and can contribute to suboptimal outcomes. Despite the fact that most physicians practice in ambulatory and primary care settings, most graduate medical training occurs in acute care hospital inpatient settings, hospital-based clinics and other ambulatory settings. Some argue that many of these settings have not been supported sufficiently to provide an optimal training ground for residents. Other factors influence the quality of GME in NYS, including Medicare and Medicaid and private payer financing of GME; reimbursement for services for low-income New Yorkers; the high numbers of uninsured New York State residents and non-residents, and consumer demographics.

The ACGME, the American Osteopathic Association (AOA), and other accrediting organizations apply progressive standards and evaluation processes to assess the quality of GME. However, some believe there may be a need for additional assessment and assistance to augment – but not duplicate – the role for accrediting bodies, particularly with the intent of improving the educational component and practice environment at some teaching hospitals. Commissioner Daines’ comments on the quality of GME focused on strengthening the educational aspects of the service component of residency training. He noted that the entwined financing of graduate medicine education and clinical services to low income patients has often led to an emphasis of service over quality education through the service component of care to hospitalized and ambulatory patients. According to the Commissioner, this problem seems to be more common in small, low-performing hospitals. His charge to the Council was to examine how NYS could enforce high standards of medical education and service.

Excerpts from Commissioner Daines’ remarks:

“The legitimate financial difficulties of well managed hospitals, the problems of staffing hospitals, the need to provide care for low income patients with state and federal coverage, and to fund indigent care until we reach near universal coverage

are best considered relatively independently of GME.”

“Most training time is still spent in the acute care hospital inpatient setting when the greater need seems to be for training in, or at least an enticing introduction to, ambulatory and primary care.”

“If GME-related funding is an essential lifeline for almost every hospital, we have in fact mandated that small, struggling, poorly staffed and poorly performing hospitals will rely in desperation on any residency program for which they can maintain accreditation. Such programs, rather than serving as a pipeline to solve current and future workforce issues, probably constitute a kind of professional workforce black hole. Bear in mind that this is occurring in communities with some of the highest levels of unmet need. Decades of supporting GME programs and the production of hundreds of graduating residents have not made much of a dent.”

II. Charge

The Council was charged to consider the following questions:

1. What changes can be implemented to ensure appropriate balance between education and service?
2. Should accreditation standards be modified by NYS to improve the quality of current and future GME in NYS and better prepare physicians to deliver high quality services?
3. Should there be fiscal consequences for non-compliance?
4. Is there continuity of care provided by residents and supervision of such care, especially for clinically complex patients?

The Council identified the following supplemental question:

5. How do we measure the quality of GME programs?

III. Discussion

Balance Between Education and Service

Accreditation standards exist to assess the quality of education and service, and the appropriate balance between the two. The issues are whether the standards are sufficient and appropriately enforced. Overall, the Council felt that these standards strike an appropriate balance between education and service and that an independent assessment by NYS would be challenging and of questionable benefit.

The essential components of service and determinants of an appropriate balance of service and education include:

- Duty hours
- Volume of patients and work
- Teaching received in relation to the time spent caring for patients
- Didactic teaching – conferences / small group / bedside teaching.
- Quality of teaching
- Scholarly activity
- Residents' subjective sense of the quality of education/experience received (perhaps the most important)
- Work environment

There are variations in service requirements by specialty that must be considered in assessing quality of the training experience, and in determining if a suitable balance exists. These variations are too complex for a single standard to apply. Salient issues pertaining to the balance between education and service are addressed in the section on the measurement the quality of GME programs below.

NYS Modification of Accreditation Standards

The central issue is whether conditions in NYS require establishing unique quality standards. NYS acted nearly 20 years ago to limit duty hours on the strong belief that this would improve the quality of GME. Our experience with the duty hours regulations is that such an undertaking can be challenging and expensive. The Council believes monitoring quality parameters offers an opportunity to enhance the quality of NYS residencies.

The Council applauds the ACGME for its pioneering work on defining six core competencies for physician training and requiring an outcomes-based assessment of performance in these areas. The “Outcomes Project” is rapidly evolving and developing more sophisticated methods of evaluation. ACGME’s extensive data collection of institutional and program details provides a 360° assessment of the quality of GME. The accreditation requirements for institutions and residency programs are comprehensive.

Accreditation standards also exist for osteopathic medical residency programs (American Osteopathic Association Program and Trainee Review Committee and the Healthcare Facilities Accreditation Program), general and specialty dental residency programs (American Dental Association Commission on Dental Accreditation), and podiatry residency programs (American Podiatric Medical Association Council on Podiatric Medical Education). All accreditation processes involve on-site reviews and documentation in support of compliance with accreditation standards. Like ACGME, the AOA uses core competencies to assess residency programs. The AOA also offers a Clinical Assessment Program for Residencies (CAP), as a mechanism to measure and improve the quality of patient care they provide their patients.

Appendix C describes the role of accrediting bodies in promoting and monitoring the quality of GME.

Consequences for Non-compliance

It is difficult to separate the issues of improving the quality of GME from the funding for GME. There must be a defined purpose to measuring quality and some means by which to motivate under-performing programs to improve. Financial incentives and consequences seem to be the logical way for the state to accomplish this, but the overall focus should be on residency program and patient care improvement.

In identifying and working with under-performing residency programs, the Council identified the following principles:

1. The quality standards should be limited to those factors the teaching hospital and/or residency program can control.

2. The quality standards should be achievable by any residency program and by any teaching hospital or academic medical center.
3. Care should be taken to avoid unintended negative consequences for the hospital and community.
4. Resources such as best practices and internal management tools should be made available to help teaching hospitals and residency programs meet the quality standards.
5. Sufficient time and resources for improvement should be built into the system, through a defined process, not unlike the process with resident duty hours.

The Council concluded that funds should not be taken from programs that are actively trying to improve. If improvements are not made within a reasonable time frame, appropriate sanctions might include the inability to participate in up-weighting or alternatively, to be down-weighted. This should be program specific so that one unacceptable program does not adversely affect all the residencies at an institution, unless institution-wide issues exist. State actions to improve under-performing programs should be coordinated with accreditation bodies.

Continuity and Supervision of Care Provided by Residents

Continuity of care is essential for all patients, “clinically complex” or not. Standards for appropriate continuity of care vary by specialty, making it difficult for the State to easily assess continuity and supervision. It would be challenging and resource-intensive to assess whether such issues are being adequately addressed across specialties. These issues are well addressed by ACGME program requirements.

Were the State to elect to supplement ACGME assessments of continuity and supervision, several tools are available:

- Patient satisfaction surveys (for continuity).

- Resident satisfaction survey (for supervision and continuity).
- Curricula requirements for supervisor's experience and written lines of responsibility.
- Evaluations of residents by supervisors.

Patient satisfaction is currently gauged by several mechanisms. Hospitals design their own surveys of both ambulatory and hospitalized patients. The Hospital Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS or HCAHPS), designed jointly by the Centers for Medicare & Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ), provides a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care. The voluntary HCAHPS survey consists of 27 items that assess critical aspects of the hospital experience (communication with doctors, communication with nurses, responsiveness of hospital staff, cleanliness and quietness of the hospital, pain control, communication about medicines, and discharge information). CMS intends to report HCAHPS results (collected monthly on a random sample of hospital discharges who are over the age of 18, had an over-night stay, and had a non-psychiatric diagnosis) on a Hospital Compare website⁶).

The ACGME administers resident satisfaction surveys to all residents training in ACGME-accredited programs (see Appendix C). To insure anonymity, results of these surveys are collated and not released to residency programs until the response rate is 70 percent. Still, residents are reluctant to express dissatisfaction with their own programs.

The Council is mindful of unintended consequences. Care provided by residents and their faculty may represent the only care available to patients in a given community. Quality measures imposed by the State that result in program reduction or closure, rather than program improvement, may "abandon" patients with an unintended negative impact on healthcare for those patients. Quality judgments based on continuity of care measures, for example, may reflect conditions in the community rather than the structure of the residency.

Inpatient "continuity" also deserves attention. This includes, but is not necessarily limited to, continuity through an inpatient stay (e.g. minimizing the number of providers that care for a patient, realizing the effects of duty hours regulations), quality of hand-offs/sign-outs, communications, and continuity of attending

involvement. A rigorous assessment of continuity of care would be quite resource intense and since accreditation bodies evaluate this through the site visit process, it does not seem practical for NYS to independently assess continuity as an isolated factor.

Disparity of care is an important quality issue related to GME. In order to ensure a single standard of care for all patients, consideration should be given to requiring residency programs and teaching hospitals to file attestations detailing how their residency clinics and inpatient services minimize disparities between patient groups based on insurance or socioeconomic demographics. The Department of Health, in conjunction with the Council, should develop or identify existing standards regarding disparity of care, such as the guidelines for Medicaid Managed Care Plans developed by the Council (see Appendix D). Programs and teaching hospitals would use these standards to measure and modify their inpatient and outpatient teaching services. Such standards should address resources, supervision, access to care (including referral services) and overall quality of care. Compliance should be monitored and could be accomplished in conjunction with current duty hours inspections. NYS also could disseminate “best practice” models from programs that are particularly successful or innovative in reducing disparities of care.

Measuring the Quality of GME Programs

The quality of GME programs is the central issue addressed in this chapter. There are practical measures NYS should take to ensure the quality of its GME programs and the patient care they provide, distinct from the global assessment of quality. The Council believes the presence of GME is evidence of higher quality clinical care, and the State’s efforts should insure that residency training occurs in the context of the delivery of high quality patient care to all New Yorkers. The Council identified several areas of concern, including:

- Ensuring high quality GME
- Promoting high quality patient care and minimizing disparities of care
- Meeting the physician workforce needs of each region and the State overall (addressed in the chapter on Physician Supply)

Ensuring High Quality Education

The Council recognizes the primacy of the ACGME's leadership in allopathic institutional and program accreditation. The Council applauds their shift to outcome measures for the six core competencies and expects that when the transition is complete, a more accurate and comprehensive system will exist for assessing the quality of GME. However, in recognition of New York's financial contribution to GME, we believe it appropriate for the State to look at selected GME issues beyond those addressed by the ACGME.

NYS should assess the quality of GME by monitoring specific parameters. Given the scope of GME across the state, a monitoring system should look at metrics that are relatively accessible and simple to obtain, and that would serve as a means to detect under-performing programs that merit further attention.

The Council supports the development of a GME monitoring system to identify and assist low-performing residency programs and institutions improve the quality of their teaching and related patient care activities. NYS should monitor basic program information, such as accreditation status and cycle length, duty hour compliance as determined by IPRO inspections, and selected hospital quality of care indicators. (The Council does not believe that the quality measures should include board pass rates and match data. Both are complex measures that could potentially be "manipulated" by residency programs in ways that would not necessarily reflect their overall quality. Moreover, board pass rates are captured by periodic accreditation reviews.) Standards should also be developed to monitor the overall quality of clinical care provided by teaching hospitals, as underperformance in this area is likely to have an adverse impact on the quality of GME.

The quality of GME monitoring system should include threshold levels that would trigger a more detailed review of a specific program, e.g. probation or warning, recurring short cycles, fines levied for duty hour noncompliance, etc. These monitoring parameters and threshold should be developed by and vetted through the full Council. Stakeholders and members of the public should be permitted to provide input before any final standards are adopted.

For programs that meet criteria for further review, the Department of Health should organize and coordinate a "peer review" system conducted by a small group of graduate medical educators and Department of Health support personnel. As one option, graduate medical educators might be invited to volunteer to be reviewers, constituting a pool from which individuals could be chosen for specific

assignments.

The Council strongly believes that there must be a realistic time frame for the residency program to make changes and the Department of Health should monitor these efforts and provide assistance as appropriate. Financial penalties should be viewed as a last resort, since they may have a negative impact on a program's ability to resolve its shortcomings.

Resident satisfaction, collected through ACGME's annual survey, was identified as an important measure for a number of quality issues within a residency program. The institution has access to its summary resident survey data, and the ACGME utilizes resident surveys in their periodic reviews. There is no need for the state to duplicate or obtain this data, except as an aid to help under-performing programs improve their programs. Likewise, patient satisfaction surveys are a good source of information about a hospital's quality of care and might aid the peer review team in helping a low-performing hospital improve its services. Available information could be sought from the hospital under reviewed.

Promoting High Quality Patient Care and Minimizing Disparities of Care

The presence of graduate medical programs should never compromise the delivery of high quality (i.e., efficient) care. Because residents may be a "transitional work force," it is incumbent on other practitioners (fully-trained physicians, nurses, etc.) to ensure that gaps in care are closed so that substandard care is not delivered. In this context, the Council believes that specific models for quality resident experiences in inpatient and ambulatory care be identified and assessed to confirm that they are adhered to in teaching settings.

The Commissioner expressed concern that at some teaching hospitals, there is a two tier system of care in which patients are directed to different types of providers (i.e. resident clinics versus attending practices) based upon their health insurance status or other socioeconomic characteristics. Such disparities can occur in the outpatient as well as the inpatient setting. Providing different levels of care or segregating patients based upon insurance into different care systems provides an environment for resident education that counters efforts to address cultural competence and health equality in the curriculum.

A separate but related concern is that ambulatory settings in which residents train and deliver care sometimes lack resources necessary for physicians to practice in a safe, efficient environment. These issues potentially impact the educational and

patient care quality of a residency program. It should be a priority to minimize such disparities, especially when GME funding mechanisms support or exacerbate these issues. Best practices in ambulatory training should be identified, analyzed, and shared with other programs/institutions.

Although accreditation bodies evaluate the adequacy of outpatient clinic sites, especially for primary care residencies, this information could serve as an important monitor for NYS. The Council suggests that residency programs and/or teaching hospitals file an attestation with the state, outlining how they assure the same standard of care for all patients. The state can then choose to conduct random surveys or assess only institutions/programs that are found to be under-performers. The goal should be to promote practices that serve the needs of all patients in ways that ensure that the presence of GME programs does not create separate and disparate systems of care.

The Council adopted Managed Care Recommendations for the use of residents in primary care and specialty residency programs in the Medicaid Managed Care program. The appropriate standards for outpatient clinic sites could be built to these guidelines (see Appendix D).

Rosenbaum, Shin and Whittington argue that networks of academic centers and community sites are necessary for educating primary care physicians and are a way to improve quality patient care and education. “Training and education programs ... need to be linked to primary care sites in order to foster the growth of skills in primary care settings, particularly settings that are located in urban and rural shortage areas... In order to function well, primary care providers must be integrated with hospitals and long term care facilities, as well as with sources of specialty care.”⁷ The authors recommended offering incentives to hospitals that facilitate linkages and maintain education in community settings.

Consideration should be given to developing new models for providing residents with quality ambulatory care experiences that reinforce the value of a high level of care for all patients. Two well-known examples of linkages between academic medical centers and community based primary care clinics are Parkland Hospital in Dallas and the University of Denver. These institutions employ a “hub and spoke” arrangement to address the community need for high quality primary care. Urban and rural teaching hospitals should be encouraged to consider innovative affiliations to integrate residency education in ambulatory settings.

Related to this issue of promoting high quality patient care is the overall relationship between the adequacy of clinical care provided by a hospital and the quality of the GME it delivers. The Council recognizes that if a hospital significantly underperforms in clinical practice, there is likelihood that the medical education it provides is also deficient. Therefore, such parameters should also be monitored.

Some measures of the quality of hospital patient care exist. NYS currently collects information on Hospital Quality and provides individual institutional records on heart conditions, pneumonia care, surgical infection prevention, and coronary care.⁸ The State also maintains a Patient Occurrence Reporting and Tracking System (NYPORTS), which monitors adverse patient events. Adverse patient events are defined as unintended adverse and undesirable development in a patient's condition. These two systems might be tapped to provide additional information on patient care at hospitals with GME programs.

In addressing these issues, it is important to avoid unintended consequences to the populations served by a residency program. If you adversely impact a program or force it to abandon those patients in order to comply with our quality measures, there may be a negative impact on the health of those patients. Before a program is penalized, we must make sure that the quality metric being enforced is one that the residency program has control over. It is also critical that the state and other payers address inadequate primary care reimbursement in order to provide better resources for primary care residency clinics.

Meeting the Physician Workforce Needs of Each Region and the State Overall

The Council has noted that this is an important issue for GME in NYS, but recognized that it did not truly fall under the "quality" umbrella. Financial disincentives that inhibit programs from sending their residents to high quality rural and community experiences should be avoided.

Promoting Innovation

An impressive variety of innovations in residency programming is improving the effectiveness of GME and the quality of patient care in NY and across the country. The ACGME, through its Educational Innovation Project (EIP) created by the Review Committee for Internal Medicine, extends accreditation cycles for a small number of approved programs, chosen largely on the basis of proposed innovations. In another initiative, the ACGME's Committee on Innovation in the Learning Environment (CILE) seeks input from programs regarding possible areas for innovation and may approve pilot projects that deviate from current program requirements.

Now is an excellent time for New York to invest in using GME funds to improve the quality of GME while ensuring state of the art patient care. NYS should consider using incentive pool funds, establishing a grant program, or developing other mechanisms to stimulate new and novel approaches to enhancing GME and improving patient safety. The Department of Health may wish to target specific areas for innovation, such as patient safety, health information technology, ambulatory care, interdisciplinary teams, patient hand-offs, improved communications between providers, and promotion of the medical home/patient home models. This is also an initiative that may lead to best practice models and successful strategies appropriate for distribution to other programs and institutions. All innovative projects approved and/or funded by NYS would need to be in compliance with existing accreditation program requirements or have appropriate approval.

⁶ U.S. Department of Health and Human Services. Hospital Compare Home Page. Accessed Feb.22, 2008
<http://www.hospitalcompare.hhs.gov>. .

⁷ Rosenbaum, S.J.D, Shin, P, Whittington RPT. " Laying the Foundation: Health System Reform in New York State and the Primary Care Imperative." Feb. 2006. George Washington University, School of Public Health and Health Services, Washington, D.C. Accessed Feb. 22, 2008
http://www.gwumc.edu/sphhs/healthpolicy/ndw_publications.cfm.

⁸ New York State Department of Health. New York State Hospital Profile. Accessed Feb. 22, 2008
<http://hospitals.nyhealth.gov>.

Physician Supply

I. Background

An adequate supply of physicians, as measured by the number of primary care and specialty providers and their distribution across the state, is essential to the overall health care of New York citizens. While there was overall growth in New York's physician supply between 2001 and 2005, more than five million people live in New York's federally designated primary care Health Professional Shortage Areas (HPSAs). Clearly, physician supply is a critical issue for New York.

New York City has 364 patient care physicians for every 100,000 in population, while rural counties have a ratio of 169 physicians. There is an ineffective distribution of practicing physicians, both in primary care and among some specialties, that creates problems in terms of access to services. In addition:

- The Finger Lakes and Western New York regions experienced physician declines of six percent and ten percent respectively.
- General surgeons declined by fourteen percent; Psychiatrists and OB/GYNs declined by one percent; Primary Care physicians declined by one to nine percent in the Finger Lakes, North Country and Western areas of New York State in the past five years (2001-2005).⁹
- Eight counties in NYS have no OB/GYNs practicing in obstetrics and 23 of the 62 counties (37 percent) have less than five practicing OB/GYNs.¹⁰
- 2/3 of the counties have between 0-3 child psychiatrists, including 24 counties with no child psychiatrists¹¹

II. Charge

The Council was charged to address New York's physician supply needs and respond to the following questions:

1. What are the current and future physician supply needs (by specialty), in

NYS and Nationally?

2. Should there be incentives to encourage medical school graduates to select residency training programs in specialties identified as being in shortage (i.e. primary care)?
3. How can GME and other incentives address the mal-distribution of physicians in NYS including physician supply in underserved areas?

III. Discussion

Current and Future Physician Needs by Specialty

New York's teaching hospitals train over 16,500 residents each year. About half of graduating residents stay in the State after completion of their training, which is slightly above the national average retention rate.¹² However, fewer New York State residency graduates have remained in areas of perceived need. Primary Care graduate retention rates dropped by 11 percent, and surgical specialties by seven percent from 2001 to 2005.¹³ It is not clear if this reflects better practice opportunities (e.g., income, malpractice insurance) in other states or the return of residents to their state of origin. Interestingly, however, about three-quarters of practicing physicians in New York performed residency training in New York.¹⁴ This suggests that New York's GME programs are critically important to meet the State's physician workforce needs, though attention may be required to ensure an appropriate distribution to underserved areas.

The first step in examining the physician supply is to define "need." Need is usually defined as "a normative judgment about the ideal number of health personnel that should be available to deliver safe, effective or high quality care" in a particular area or population, regardless of ability to pay.¹⁵ This definition addresses both the number of physicians and their distribution. National standards exist for comparison to NYS statistics.

One obvious strategy to increase the supply of physicians is to increase the number of medical school graduates. The Association of American Medical Colleges (AAMC) has called for a 30 percent increase in physicians by 2020.¹⁶ NYS medical schools plan to increase the number of students graduating by

approximately 175 by 2012. This includes two new medical schools that are currently under consideration in NYS.

The AAMC 2006 Medical School Graduation Questionnaire survey identified key factors that graduating medical students consider in determining their area of specialty. The four factors with strong to moderate influence were mentor/role model (75 percent), lifestyle (71 percent), options for fellowship training (63 percent), and salary expectations (49 percent)¹⁷. These data show that, given proper guidance and incentives, medical students and presumably residents, can be directed towards specialties in need and to needed areas.

Physician supply in NYS is affected by not only how many new physicians need to be produced in a specialty each year but also by: (a) the rate at which physicians are retiring from that specialty; (b) whether physicians are retiring prematurely and if so, why, and (c) factors which make it increasingly difficult to recruit appropriately qualified candidates into residency positions in particular specialties in New York State and to enable them to remain in practice in the state.

Fewer physicians are entering specialties such as primary care internal medicine, family practice, and obstetrics due to very low reimbursement rates, making it difficult to pay off their student debts while managing high practice expenses. Primary care physicians, in general, are finding it more difficult to find suitable practices. This is particularly true in areas that do not provide them with the professional and personal environment to meet their needs. To meet the supply needs, these aspects of the practice environment must be addressed both to attract graduating medical students to particular specialties and to retain currently practicing physicians in those specialties.

Determining physician supply needs by region and by subspecialty is difficult. Currently, the Center for Health Workforce Studies, with support from the New York State Department of Health, is conducting an assessment of the future supply of and demand for physicians in New York through 2020. Using physician forecasting models developed by Health Resources and Services Administration (HRSA) and adapted to incorporate data specific to New York, the Center will apply a number of different supply and demand scenarios to estimate physician workforce requirements in New York by region and by specialty. The Center anticipates releasing this study in March 2008.

In addition, a periodic, statewide data collection system on consumer access to and

use of health services would be invaluable to planners, policy makers and health care providers across the state, allowing all to better understand and address the unmet health care needs of New Yorkers.

The Center for Health Workforce Studies also has the capacity to conduct a New York State Community Health Survey. This would be a biennial telephone survey of a sample of households across the state to collect information on health and access to health care services. This survey would be modeled after the California Health Interview and would build on the Community Health Survey that is currently conducted by the New York City Department of Health and Mental Hygiene. The survey would collect data on a broad array of topics, including, but not limited to: health status; health conditions; mental health; health behaviors; women's health; cancer history and prevention; dental health; injury; food insecurity/hunger; access to and use of health care; health insurance; public program eligibility; neighborhood and housing; employment; income; and respondent characteristics.

The Council is aware that many of the prior physician supply predictions were inaccurate. However, workforce studies are necessary to answer the question concerning current physician supply and future needs. There are limitations to long-term projections, but short-term projections, which are constantly reviewed and refined, would be of help. Systematic tracking of physician supply and distribution in the state is a useful strategy in the identification of medical workforce issues.

Incentives for Graduates to Select Specialties

There are several approaches to provide incentives for physicians to train and practice in underserved areas in primary care and subspecialties in need. One such strategy is to dedicate a limited number of residency positions (i.e., one to three positions) in teaching hospitals for such needed specialties. Medical schools will be encouraged to provide mentoring and guidance to students to consider these residency positions.

Medical students who accept these dedicated residency positions would enter into a contractual obligation to practice in a designated underserved area in NYS for a specific number of years (i.e., three to five years). These physicians would be eligible for incentives such as loan repayment, practice and community support.

Teaching hospitals would be eligible for additional upweighting or Incentive Pool funds for these positions.

Another method to attract primary care and subspecialty physicians to underserved areas in need is to link very desirable subspecialty fellowships with primary care training. Such fellowship positions would be available and guaranteed only to physicians who first agree to complete a primary care residency in an underserved area. Primary care residents in this program would provide needed medical service in these underserved areas while in training and may opt to return to the community after completing their subspecialty fellowships.

Incentives to Address the Maldistribution of Physicians

In 2006, the Council, in collaboration with the Rural Health Council, recommended a substantial loan repayment program for physicians and dentists in rural areas. This proposal would provide physicians and dentists with funding to repay their educational debt in exchange for a service obligation in an underserved area. Additional financial incentives could also be provided for practice support and to recruit physicians to work in underserved communities. Innovative methods for these awards, such as increased payments for continued years of service or reduced tax liability on the award, should be considered.

The Council also believes updated information is necessary on current programs that encourage physicians to practice in both geographic and specialty areas of need. The following programs and studies should be reviewed for their effectiveness:

- Analyze current residency programs to identify specialties for which there is declining demand in NYS. The resulting data may provide an opportunity to reallocate residency positions from one specialty to another. The impact of residency reallocations on hospital services must be considered.
- Examine specialties that are in short supply for which there are imminent patient access crises as well as potential intermediate and long-term physician supply issues.
- Review the rural medicine education programs at SUNY Upstate Medical University and at Jefferson Medical College (Pennsylvania). These are two examples of effective programs that allow students to obtain clinical

experience in rural communities and experience the rural lifestyle. These programs help to address the long-standing shortage of physicians in rural areas by recruiting students who are familiar living in a rural area and who are inclined to practice medicine in such areas.

- Study pipeline programs currently administered by the Department of Health, Associated Medical School of New York, AHEC and the State Education Department have helped attract rural and underserved minority students into health care professions. The experience of New York's AHEC program suggests part of the solution lies within enrolling medical students who hail from rural communities since these students are more likely to return to practice in these communities. Pipeline programs should be extended into elementary school settings and should include work with guidance counselors and others who influence career choices for students who may return to serve their communities of origin.

Other Options to Retain and Attract Physicians

If the aforementioned strategies do not succeed to a degree sufficient to meet needs, then initiatives such as reviewing foreign medical graduate enrollment in residency fellowships and in practice must be studied. Extending requirements for practice in underserved areas may be a desirable strategy.

To combat the issues that make medical practice in NY difficult, the practice environment in NYS must change. Specifically, there must be tort reform, increased reimbursement from almost all payors, equitable distribution of hospital reimbursement across specialties, an improved regulatory environment and a reduction in the high cost of practice. In addition, the need for higher reimbursement for cognitive specialties is compelling. Inequitable financial compensation continues to be a major issue that contributes to problems in the selection of physician specialty career choices.

It is recognized that all of the proposed strategies will require additional funding or the redistribution of funds from existing programs. Therefore, it will take efforts on the part of the Governor and legislators at the state and federal level to effect changes that are absolutely necessary to ensure access and high quality care.

The Commissioner has indicated that given the amount of funds New York

currently spends on GME, we should be able to reorganize without additional costs. However, if sufficient funding from current resources is not available, funding from third party payors, insurance companies and the pharmaceutical industry could be a resource to sustain these programs. Resources also may be obtained by tapping on the financial savings of significant tort reform, regulating and redirecting the profits of insurance companies to the beneficiaries of health care service and limiting the bureaucracy and practice expenses for physician practices and hospitals. In addition, since NYS provides medical education for the nation's physicians, additional federal support should be sought in recognition of this unique role.

⁹ Annual New York Physician Workforce Profile 2006 Edition. Center for Health Workforce Studies, University at Albany, School of Public Health. 2006.

¹⁰ Red Alert. The American College of OB/GYN, District Two, New York. April 2007.

¹¹ Improving Access to Child Psychiatric Services. New York State Conference of Local Mental Hygiene Directors, Inc. 2005.

¹² Residency Training Outcomes by Specialty in 2005 for New York: A Summary of Responses to the 2005 New York Resident Exit Survey. Center for Health Workforce Studies, University at Albany, School of Public Health. ES-5.

¹³ Ibid, Figure 3.2.

¹⁴ New York Physician Workforce Profile 2006 Edition.

¹⁵ Prescott, P. The enigmatic nursing workforce. *JONA: Journal of Nursing Administration*. 2000; 30 (2), 59-65.

¹⁶ Association of American Medical Colleges (AAMC) Statement on the Physician Workforce. June 2006.

¹⁷ Medical School Graduation Questionnaire All School Report. Association of American Medical Colleges. 2006.

Biomedical Research

I. Background

In New York, a positive relationship has been drawn by some between GME funding and success in biomedical research. The Commissioner understood comments made at a meeting with deans of medical schools that state cuts in GME funding would immediately and substantially cut into the competitiveness and success of biomedical research at their institutions. He then commented that institutions must pay meticulous attention to ensure there is no commingling of funds dedicated to patient care with research funding, and that the National Institutes of Health (NIH) apply the same rigorous standards.

Using NIH funding as a measure, New York's biomedical research position has declined from one to three, behind California and Massachusetts. Over this period of decline, GME funding has been advancing at per resident costs well beyond those of states such as California and Massachusetts. Furthermore, there are institutions that receive high per resident amounts and have very little or no research to show for it. As a result, it appears as if the influence of GME funding on biomedical research is not as substantial as some may believe.

II. Charge

The Council was charged to explore the correlation of GME funding and biomedical research. The Council expanded upon this to investigate the following questions that were believed to be associated with the focal point:

1. Is there and should there be a correlation between GME funding and research?
2. Are there aspects of research, particularly educational, that are appropriate to fund with GME dollars?
3. Should hospitals, even those without research missions, receive this support?
4. Is there an issue around commingling of education and research dollars?
5. What is the evidence that support through GME dollars leads institutions to

better recruit researchers and gain research dollars?

6. Is NIH-funding an appropriate single benchmark to assess the impact of GME funding on biomedical research in New York?

III. Discussion

The charge to the Council regarding the correlation between GME funding and biomedical research precipitated two distinct areas of discussion. The two issues that were expanded from the charge were the use of GME funding in the process of teaching about research to residents and the use of GME funding directly in support of research.

Research as an Education Tool

GME research-oriented funding is in clinical areas and comprises case reports, poster presentations, journal clubs, and at academic centers that have actual independently financed research programs, an occasional rotation during residency and possibly a more prolonged exposure during a two or three-year fellowship. Case reports evolve during the residents' care and treatment of patients, amplified by information obtained from researching various articles, books, and from the teaching of supervising attendings, specialists, senior residents and fellows. Unusual cases can result in articles for publication or posters for presentation at national conferences. This type of research is absolutely essential for the proper education and training of competent physicians and is funded appropriately in all GME programs, including those in community hospitals as well as in medical school associated hospitals. Likewise, time spent in journal clubs learning how to critique and evaluate published information, statistics, etc. is an appropriate cost.

A perfect example of the value of this type of scientific training was demonstrated during the recent West Nile Virus outbreak in New York City. The investigation was initiated by physicians during clinical rounds at a Queens community hospital discussing a cluster of similar patients with acute encephalitis, all from a local neighborhood. This resulted in the eventual diagnosis and containment efforts which have had great national significance, enhancing NYS as a leader in medical science. The residents involved gained considerable research experience working with Infectious Disease Specialists, NYC and State Department of Health, the

Centers for Disease Control, Veterinarians and Zoologists, as they gathered, analyzed, presented and published the data.

These research programs, when present, enhance the education of residents by exposing them to the scholarly pursuit of evidence necessary for them to diagnose, treat and inform their patients. Hospitals with residency and fellowship programs attract independent research grants and funding because of the educational environment created by GME. In this sense, the ability to attract these world-renowned researchers, along with grants, could very well be limited by any decrease in GME funding.

Accreditation Standards

The ACGME defines specific program requirements, including research, for residency education in the various disciplines. Training programs must conform to these requirements to become an accredited training program.

The ACGME states some training programs (i.e., neuroradiology) “...must also provide fellows with opportunities to conduct research in the field of neuroradiology.”¹⁸ The ACGME internal medicine training programs require that:

- “The curriculum must advance residents’ knowledge of basic principles of research including how research is conducted, evaluated, explained to patients and applied to patients.”
- They also dictate that faculty be involved in a research environment, “The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.”
- In addition, “Some members of the faculty should also demonstrate scholarship by one or more of the following: (1) peer reviewed funding; (2) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks; (3) publication or presentation of case reports or clinical series at local, regional or national professional and scientific societies...”
- “The program must provide an opportunity for residents to participate in research or other scholarly activity, such as: original research; comprehensive case reports; or review of assigned clinical and research

topics.”

- Lastly, “Conferences should include information from the basic medical sciences, with emphasis on the pathophysiology of disease and reviews of recent advances in clinical medicine and biomedical research.”¹⁹

Similar language about research requirements for (some) faculty involvement in peer reviewed funded research are found in the ACGME program requirements for surgery. The ACGME requires that, “While not all members of the faculty can be investigators, clinical and/or basic science research must be ongoing in the residency program and based at the institution where residents spend the majority of their clinical time...” Furthermore these requirements state, “The participation of residents in clinical and/or laboratory research is encouraged.”²⁰

In addition, anesthesiology training programs must “have the resources to provide a research track of up to six months devoted to laboratory or clinical investigation. For the residents who elect this track, it is expected that the results of the investigations will be suitable for presentation at a local, regional or national scientific meeting.”²¹

Research Industry and Faculty

Funding provided through the GME mechanism is not necessarily pivotal in direct research support, however, it is a driver in the recruitment of faculty. As the foundation of teaching institutions, faculty engage in a three part mission which includes research, clinical practice and teaching. All aspects of a teaching institution are influenced by the faculty base, therefore they must sustain some recognized research in order to draw and maintain qualified faculty to participate in teaching as well as provide quality clinical care. However, frequently when a hospital has limited resources, appropriate funding may not be available for faculty recruitment or development. As a result, the faculty, a critical aspect of a teaching institution’s mission, suffers. Therefore, State funds earmarked for faculty recruitment and development would help institutions to be competitive in the recruitment of faculty and engage in the three part mission.

Consideration must also be given to the crossover that occurs between research and education by faculty. For instance, a faculty member that is fully funded through research grants may participate in resident education through teaching or

mentoring and will not receive GME funding for this. So, although there is separation between the education of research and actually conducting research, there is a measure of intellectual sharing. Faculty is asked to participate in patient care, research and education and in turn need to draw funds from all available resources.

Another key point is the importance for New York State to invest in the biomedical research industry. The inclusion of \$600 million for stem cell research and development in the 2007-08 State budget is a significant step. An infrastructure needs to be built around biomedical research to draw influential enterprises which in turn will attract high quality researchers and more NIH funding. The state has taken similar ventures in such technological industries as nanotechnology. With a similar investment in biomedical research, New York could return to its former leadership position.

The Council concluded that data are needed on research funding in other states to draw a valid comparison to New York's funding and the role of NIH awards. In addition, data on how New York institutions use GME labeled dollars to support biomedical research are needed. As the Council draws conclusions on GME labeled funding, support for biomedical research should be considered. However, although it is appropriate to use GME labeled dollars in the education of research, these dollars should not be directly supporting the research infrastructure that is unrelated to education and other State sources of funding need to be considered. Biomedical research is a valuable and important part of an institution's mission and funds still need to be directed to them to continue this endeavor. However, the GME funds need to be delineated from aspects of research that are not apparent to education.

The Role of the Council

Since its inception, the Council has developed many activities designed to improve GME and to ensure that citizens of New York State have sufficient educational opportunities to enter into various medical and other health education opportunities that exist in New York State. As the Council's work proceeded, members were reminded of a very important study published in the Journal of Urban Health in 1997.²² This study indicated that eastern United States and New York State, in particular, were beginning to lose valuable federal reserves that came to the State

almost routinely for the conduction of biomedical research and medical advancements. Their findings were a concern to members of the Council because they indicated that New York State, once the unquestioned leader in biomedical sciences, was now sharing the role with the medical schools and research centers that were being developed throughout the United States. The Council's response was to develop a program that would ensure that New York State would retain those many gifted physicians and clinical scientists, who would otherwise populate many areas of the country, other than in New York State.

New York's Empire Clinical Research Investigator Program (ECRIP) was created as an objective of the GME Reform Incentive Pool to provide opportunities for post-resident trainee physicians to participate in formal training of clinical research for a maximum period of up to two (2) years. ECRIP has been organized so the pool of candidates is diverse and to provide opportunities for expanding clinical research throughout New York State. Funds are awarded at \$60,000 per year for salary and fringe benefits for each clinical researcher trainee. Teaching hospitals must provide equivalent funds for other support including overhead and the salary of the supervising sponsor/mentor. From the period of 2001 – 2007, ECRIP has funded 358 projects at 50 teaching hospitals and three GME consortia for a total of \$32.1 million.

The Council has collected information on those researchers that have completed an ECRIP fellowship to gather information on their career direction. Of the 105 researchers that have completed the program, 70 percent have remained in research and of those, 75 percent have remained in New York State.

Therefore, the Council believes that it has taken an important step in serving future scientists, not only trained in New York State, but to remain as viable physicians and clinical investigators residing in New York State. Additional funding should be considered to increase support ECRIP fellows as well for the recruitment of accomplished faculty.

¹⁸ Accreditation Council on Graduate Medical Education. Residency Review Committee. Diagnostic Radiology: Neuroradiology Program Requirements. Accessed Feb. 22, 2008 http://www.acgme.org/acWebsite/navPages/nav_comPR.asp.

¹⁹ Accreditation Council on Graduate Medical Education Residency Review Committee. Internal Medicine Program Requirements. Accessed Feb. 22, 2008 http://www.acgme.org/acWebsite/navPages/nav_comPR.asp.

²⁰ Accreditation Council on Graduate Medical Education. Residency Review Committee. Surgery Program Requirements. Accessed Feb. 22, 2008 http://www.acgme.org/acWebsite/navPages/nav_comPR.asp.

²¹ Accreditation Council on Graduate Medical Education. Residency Review Committee, Anesthesiology Program Requirements. Accessed Feb. 22, 2008 http://www.acgme.org/acWebsite/navPages/nav_comPR.asp.

²² Sturman, LS, Sorin MD, Larkins E, Cavanagh KA, DeBuono BA. Losing Ground: NIH Funding to New York State Researchers. *Bull. NY Acad Med.* 1997;74(1):6-14.

Cultural Competence and Diversity in Medicine

I. Background

For purposes of this report, the Council is using the Department of Health definitions for culture and underrepresented minorities. Culture consists of a body of learned beliefs, traditions and guides for behaving and interpreting behavior that are shared among members of a particular group. This includes values, beliefs, customs, communication styles, behaviors, practices and institutions with visual aspects of culture such as clothing, art and food. Health care provisions in the context of cultural competence consists of awareness and recognition of cultural differences and the impact they have on interactions with health care professionals and health practices as well as an ability and willingness to adapt to fit a patient's culture. The Department of Health considers underrepresented minorities to include: Blacks/African Americans; Hispanics; American Indians and Alaskan Natives.

New York has a diverse population. There are an estimated 200 languages spoken in the state and one third of the residents are minorities. The diversity of the physician population does not reflect the diversity of the State minority population. Ten percent of physicians in urban counties are underrepresented minorities, compared to seven percent in rural counties. Twelve percent of physicians in downstate New York are underrepresented minorities, compared to six percent upstate. Underrepresented minorities are more likely to practice in hospitals and clinics, to report a primary care specialty, and to serve Medicaid patients than were non-minority physicians. In New York City, underrepresented minorities are more likely to practice in Health Professional Shortage Areas. Underrepresented minorities also reported more difficulty in finding a satisfactory practice position compared to all physicians, and are burdened by more educational debt.²³

II. Charge

The Council was charged to discuss and answer the following question:
How can GME improve cultural and linguistic capability and competency for our residents?

III. Discussion

The Council was enthusiastic that Commissioner Daines identified a new opportunity to emphasize the importance of cultural competence and cultural sensitivity in GME. The Commissioner's observation that the Council might promote a working knowledge of a modern language other than English, as a pre-requisite for medical school is both practical and needed. His comments reinforced the Council's desire to develop opportunities using existing GME funding to support justifiable efforts in Cultural Competency training. Through these means, the Council could support the State's initiative to address physician shortages, particularly where minority physicians are concerned.

The following excerpts from Commissioner Daines' speech were examined in depth during the deliberations:

"We are really not closing the cultural and even relatively simple language gaps between our physicians and our most needy patients."

"I would like to recommend a concrete step to address the language gap between physicians-in-training and practice and the needs of many of our most underserved populations."

"I believe there is a way to use the length of the pipeline and the consistent attractiveness of medical careers to address the language gap."

"I don't recall anyone suggesting something that could be cut to make room for successful language training."

"Support a simple requirement that: our medical and osteopathic schools to jointly support a simple requirement: that applicants for medical school in New York—beginning several years from now—would have to demonstrate satisfactory verbal and written fluency in a modern, non-English language."

The Council appreciates the issues and current data regarding workforce and cultural sensitivity in NYS. It has established a record of promoting effective programs to support GME, with an emphasis on increasing the proportion of underrepresented minorities in medical schools. One example is the April 2005 symposium on the Mentoring of Minority Medical Students, organized in collaboration with the New York Academy of Medicine and the Associated

Medical Schools of New York.²⁴ There have been additional efforts to encourage underrepresented minorities to enter medicine and other health care professions (see Appendix E). In addition, the Minority Grant Program has provided \$6 million to 10 medical schools since 2002.

A 2006 report from the New York State Minority Health Council to the Commissioner of Health underscored the importance of maintaining and improving the presence of under-represented minorities in providing access to health care in New York State. It also recognized that meeting the goal of eliminating health disparities would “require that all contractors provide culturally and linguistically appropriate services”.²⁵ This rationale pertains to every medical professional in New York State, and especially to physicians.

More recently, the Council heard presentations on the physician workforce in NYS by Jean Moore, Director of the Center for Health Workforce Studies, University at Albany. The observation was made that the profile of New York’s physicians are not representative of its population. The Center’s data support that both the geographic distribution and the specialty allocation across our state and institutions are not reflective of the cultural and racial diversity in NYS.²⁶

Need for Data on Minority Physicians

The Council believes it would be useful to query NYS institutions on their minority faculties. Such a study would add to the understanding of minority faculty recruitment and retention efforts, and would allow tracking of minority faculty across the State. For example, it would be important to know which faculty are being retained and if the number of minority faculty is growing or declining. With this information, additional supportive strategies to increase the number of minority faculty numbers and to address distribution issues can be developed and implemented in a timely and effective manner. This group should be engaged in any process that is intended to improve cultural sensitivity within the medical profession in New York State.

It is also critical to assess the numbers of minority medical school applicants who apply and subsequently accept entry to NYS Medical Schools. It would be useful to know what percentage of our minority medical school applicants continue their education and become physicians who are retained and practicing within the NYS. Accurate information would allow the State to develop incentives (i.e., scholarships) to attract and retain these students.

Defining Cultural Competence

There is concern that the monitoring of teaching hospital participation in cultural competency training is not effective. There is further concern that funding provided for cultural competence may have been used to support other priorities important to teaching facilities, but not directly related to improving cultural competency among physicians.²⁷

The national Council on Graduate Medical Education has determined that it is the prerogative of individual institutions to define cultural competence. This approach allows institutions to localize their programs, but it precludes benchmarking, and does not allow the State to assess the applicability of programs to suit the anticipated needs for physician resources within the State.

The Council concludes that it is critical to define what constitutes cultural competency and a minority faculty status. Only then can a survey of all medical schools be performed using consistent criteria.²⁸ Clarifying what defines a “minority faculty member” in New York State should be a part of this task. This effort should be a process with tracking and trending of results.

The Council maintains that the State should define its own criteria for achieving cultural competence. These criteria will allow the State to compare current programs in geographic areas or across the state. The Council supports the use of a broad definition of cultural competence, one that includes some topics often overlooked.

The Council believes that cultural competency training should also reflect the unique needs of special populations including those of families and children with developmental disabilities and should ideally expand the medical resident’s knowledge of the community resources and medical services for children with developmental disabilities.

Another area that should be included in an ideal cultural competency program is recognition of cultural competence issues for geriatric patients. The unique needs of our growing geriatric population in New York State demand that individualized training programs be developed to educate and train medical students and residents in the knowledge, skills and attitudes necessary to care for our older patients for today and tomorrow. Programs should be designed to

target an evaluation for safety in our elderly population, evaluation of mental status and treatment of dementia, hearing, vision and gait stability, and evaluate and treat our elderly patients for depression.^{29, 30, 31, 32}

Little is known about the specific medical needs of our State's future population. However, it is unlikely that future needs will be significantly different from currently identified needs. AHRQ has identified that "almost one in three adults living in rural America is in poor to fair health. Nearly half have at least one major chronic illness. Yet, rural residents average fewer physician contacts per year than those in urban communities."³³

AHRQ has convened rural health experts to help develop an agenda to tackle the following issues and to define research methodologies that ultimately can improve the following concerns: access to care; supply of primary care physicians and other health care providers; health promotion and disease prevention; health care technology implementation, and organization of services for vulnerable rural populations.³⁴ It is critical that the GME programs in New York State continue to address and support these needs in rural medical education.³⁵

Collaboration with Other Groups

The Council sees collaborative projects with the AMSNY, the Minority Health Council, the Medical Society of the State of New York (MSSNY) and the National Medical Association (NMA), among others, as particularly fruitful in enhancing cultural competence training. Such collaboration could minimize duplication of effort and identify best practices that would serve as models for successful program implementation. Shared costs or collaboration on grant applications and implementation would benefit all.

Based on Commissioner Daines' declaration that New York State would benefit from emphasizing excellence in its GME programs, the Council could prepare a comprehensive best practices compendium. The project could include information from medical schools about their cultural competency and/or health literacy training. A variety of topics, such as faculty development activities in cultural competence, innovative teaching methods, foreign language acquisition programs and incentives, and the use of interpreters could be included.

One program of particular importance is MSSNY's work on health literacy and cultural competency through its Task Force to Eliminate Racial and Ethnic

Health Care Disparities. Using the American Medical Association's health literacy program, MSSNY has trained over 600 physicians in a series of seminars and hospital grand rounds over the past year and a half. Cultural competency issues frequently arise during these discussions. In addition, MSSNY is developing a curriculum on cultural competence and foreign language proficiency for physician continuing medical education.

A second area of cooperation would be the inclusion of a second language requirement, besides English, for entry into or for graduation from medical school. While the details of how a non-English language requirement might be defined and implemented would need to be negotiated, the collaboration of interested professional and provider groups should be pursued.

The Council views the AAMC as uniquely positioned to identify and publicize best practices in cultural competence training, and to complement the Council's efforts to increase and expand cultural competence training. One of the AAMC's primary missions is to "assist academic medical institutions, organizations and individuals" in medical education. The membership of this organization consists of all 125 accredited medical schools in the United States, and the 17 accredited medical schools in Canada. Also included in this membership are nearly 400 major teaching hospitals, including 90-affiliated health systems, and 68 Veterans Affairs Medical Centers. Over 109,000 faculty members are represented through their affiliated academic and professional societies. All of the nation's medical students and residents are engaged with this organization.³⁶ AAMC works with its members to address national issues in medical education. Working with the AAMC could provide a needed boost to enhancing cultural competence training in medical schools and residency programs.

Collaboration with the Minority Health Council and the NMA would enhance efforts to define what constitutes cultural competency and a minority faculty status, and to identify best practices in training. With the Council's leadership, significant work can be done to make New York a leader in promoting cultural competence in medical schools and residency programs.

²³ Moore, J. (2006, December 11). "Update on Physicians from New York State Findings from Recent Studies", Presented to the New York Council on Graduate Medical Education.

²⁴ Associated Medical Schools of New York. Mentoring Minority Medical Students Conference Outcomes and Future Goals. New York, NY. 2005.

²⁵ The New York State Minority Health Council Report. November 2006.

²⁶ Moore 2006.

²⁷ Newhouse JP & Wilensky GR. Paying for Graduate Medical Education: The Debate Goes On. *Health Affairs* 2001; 20(2): 136-147. © 2001 Project Hope.

²⁸ Sullivan, LW. (2005). Missing Persons: Minorities in the Health Professions. A Report of the Sullivan Commission on Diversity in the Healthcare Workforce. Retrieved Feb. 25, 2008, from <http://www.aacn.nchhe.edu/Media/pdf/SullivanReport.pdf>.

²⁹ The New York State Minority Council Report. November 2006.

³⁰ Newhouse JP & Wilensky GR. 2001.

³¹ Alexapoulous GS. Geriatric Depression in Primary Care. *Int J Geriatr Psychiatry*. 1966a; 11:397-400.

³² Caselli, RJ. Current issues in the diagnosis and management of dementia. *Semin neurol*. 2003; 23(3):231-240.

³³ Agency for Healthcare Research and Quality. Improving Health Care for Rural Population. AHCPR Publication No. 96-PO40 Current as of March 1006. Accessed August 24, 2007 at <http://www.ahrq.gov/research/rural.htm>

³⁴ Ibid.

³⁵ Smucny J, Beatty P, Grant W, Dennison T., Wolff LT. An Evaluation of the Rural Medical Education Program of the State University of New York Upstate Medical University, 1990-2007. *Acad Med*. 2005; 80(8): 733-738.

³⁶ Association of American Medical Colleges. About the AAMC Accessed August 24, 2007 at <http://www.aamc.org/about/>

Appendix A

Remarks delivered by Richard F. Daines, M.D. NYS Commissioner of Health at the Council's Plenary Session on June 18, 2007

I appreciate this first opportunity to meet with the Council. I have met many of you and I look forward to getting to know the rest of you. First, I want to thank you for taking time out of your busy schedules to volunteer your expertise on this Council. You have provided advice on some important GME issues in the past, and your input will continue to be valuable as we move forward.

I am, from start to finish, a product of the undergraduate and graduate medical education system of New York:

- My wife and I came east from Utah in 1974 so I could attend medical school in New York City. At graduation we intended to immediately return to the west, but medical school in New York led to an internal medicine residency in New York City.
- That residency led to a "temporary, one year" position at an affiliated hospital in the Bronx.
- In 19 years in that temporary position at St. Barnabas, I was the founding director of its ACGME accredited internal medicine residency program. I helped bring a variety of osteopathic residency programs to the hospital and served as the first overall Chief of Graduate Medical Education.
- I grandfathered into the first critical care medicine boards, having trained under and worked with Joe Parillo and Vladimir Kvetan, two of the founders of the formal field who were themselves both products of New York's GME system. We built the hospital's medical staff from products of New York's GME system.
- At St. Luke's-Roosevelt, I was Chairman of the Graduate Medical Education Committee and then turned that over to Ethan Fried, a brilliant medical educator. As CEO I continued to work closely with Ethan and attended most GMEC meetings, partly because I knew how critically important those programs were to the hospital's success and partly for the sheer pleasure of engaging with my colleagues in that forum while escaping my other administrative concerns.
- My oldest son just finished his third year of medical school in New York, exactly 30 years behind me.

However, over the many years I have been involved with GME I have become increasingly concerned by aspects of the role graduate medical education and its financing have assumed in New York.

I need to be clear. My concern is not with the good intentions, professionalism and integrity of our GME trainees, faculty, leaders and those above them in the training institutions.

My concerns chiefly have to do with all the external pressures, expectations, demands and perverse incentives piled upon GME in New York.

Like Australian marsupials, New York GME has evolved differently here than in most of the rest of the country. Enormous resources are channeled through GME and vast expectations are raised for fulfillment by GME. If we fail to deliver on those expectations, GME may be held to blame.

In New York, a number of inarguably important public goods – from physician supply and distribution, to hospital budget gap closure and indigent care, to research competitiveness – have been linked by decision and by default, explicitly and implicitly, to graduate medical education.

The linkages are not, as the CIA might say, 'slam dunks.' In some cases, there may be no link or even a negative relationship. Or the linkage may act to the detriment of GME itself.

Most states have moved in significantly different directions to provide for these public goods while maintaining healthy GME enterprises.

New York is a dramatic outlier. Year after year our model grows more aberrant and we have increasing difficulty justifying it on the merits and prevailing on the politics.

On the merits, it is an increasingly hard slog to explain why our costs per resident and our total share of the national pie appear to be so wildly disproportionate to our size.

I know the arguments and justifications, but the facts are at very best murky, and there are very valid counters to most of our arguments.

Medicaid pays about \$77,000 for each resident in NY supplemented by additional significant state-only funds. In contrast, California seems to spend \$21,000 in Medicaid per resident.

I dislike entering a national argument on the merits with murky facts, little company and, at first and perhaps second examination, a less than persuasive starting point.

The national politics hinge from time to time on the perspectives of a California Republican congressman, a Montana or Iowa senator or the usual cycles of presidential elections.

Maybe we can count on an unbroken chain of influence from the late Daniel Patrick Moynihan to Senators Clinton and Schumer and Congressman Rangel and their colleagues and successors. But it's almost as if we are counting on a perfect storm to sustain us routinely from year to year.

Inside New York State, the realities of the demands on the state budget and the unrealistic expectations assigned to GME do not necessarily favor continuation of the GME status quo. Nor do upstate and rural interests necessarily match those of the downstate hospitals.

Ten days ago at a banquet, I shared in the relief when a New York hospital industry leader announced that the latest Washington threat to eliminate Medicaid support for GME had been blocked. The cut would have been devastating.

However, he went on to say something like, 'GME is to New York as the auto industry is to Detroit.' Given long-term trends and recent events involving Detroit's leading industry, I'm sure I wasn't the only person there to feel a sudden wave of anxiety.

My concerns with GME financing pre-date my assumption of this new position. They grow out of my experience in the system and from my knowledge of how difficult it would have been to run and staff my hospitals without GME.

My experience and these concerns were probed in depth before I received the nomination. We continue to discuss them inside the department and in meetings with Deputy Secretary Whalen and Governor Spitzer.

As I said, I am uncomfortable both as a medical educator and as one who believes in the public responsibility to provide good health care, on our reliance on GME programs and reimbursement as the best or perhaps only means of achieving certain public goods. I am particularly concerned when I compare the vast investment made in GME with the meager results in those areas of public interest.

New York spends \$47 billion from all sources on Medicaid of which \$1.4 billion goes to support GME, representing one-third of all Medicaid funding spent on

GME nationally. Medicare currently spends about \$1.7 billion on New York's GME program and additional funds flow to GME for a total of \$3.4 billion.

I suppose in that sense we are the Detroit of GME. But what is the state getting in return on this investment? I will not repeat today what has been said many times recently about the actual health status and quality of care of New Yorkers on the receiving end of these huge investments.

But if reliance on GME-centric models were the solution, wouldn't we expect better results in New York?

I will focus on **four specific concerns** related to GME.

First, there is a problem heading towards crisis across New York in the supply, specialization and geographic distribution of the practicing physician workforce.

In the first weeks in my new position I heard from several major groups that addressing this would require major new investments in GME. This same theme -- that New York's GME system, largely as it is but further expanded, enriched and empowered, is the key -- is taken up by some party in virtually every discussion on physician workforce issues.

If supporting the nation's largest, most expensive GME program were the answer to workforce shortages, New York would already be Nirvana. We would not be experiencing the problems in physician supply, distribution and cultural and linguistic skills seen in the rest of the country.

With that \$3.4 billion from all sources, we have nearly 16,500 residents in training, vastly more in proportion and at more expense than in any other state. Perhaps we are helping solve workforce problems outside of New York or abroad.

Nevertheless, here in NY:

- Approximately 50 percent of our residents leave New York State after completing their training.
- New York State has a serious maldistribution of physicians in regions and specialties across the state. Many areas are experiencing serious current shortages of both primary care and specialties.
- New York has tried various GME add-ons and incentives to direct more physicians to work in these shortage areas, and none seem to be working.

- Most training time is still spent in the acute care hospital inpatient setting when the greater need seems to be for training in, or at least an enticing introduction to, ambulatory and primary care.
- Ambulatory care training instead is provided all too often in un-reformed hospital-based clinics with the difficult working environments, poor continuity, and suboptimal outcomes that earned them the title of academia's "ugly duckling" decades ago. Forced experience in them may serve more to drive graduates out of primary care and out of New York.
- We might be better to adopt what I'd call the "Tom Sawyer" approach. Remember when he told gawkers that whitewashing a fence on Saturday was so fun and so special that he really wasn't inclined to let anyone else do it? Soon they were begging for the chance. Maybe we should keep primary care and rural medicine off limits to trainees, just tell them it's such a wonderful, rewarding experience that attendings just won't share it with trainees. Or maybe we should improve the post-training environments and rewards for practicing in underserved areas rather than focusing on GME as a stopgap solution.
- We are really not closing the cultural and even relatively simple language gaps between our physicians and our most needy patients. More on that later.

Second, I am alarmed that funding channeled through graduate medical education has come to be regarded as a general and essential hospital revenue stream rather than as a proper payment for the proper costs and value of GME itself.

My introduction to Albany was during the budget process including the "phantom resident" debate. The industry's response, and this comes in virtually any discussion of GME, was that payment for phantom residents was a case of "identity theft" – that what was being funded as GME really was meant for different purposes, some shifting combination of making up for other shortfalls in reimbursement, fulfilling prior deals, providing indigent charity care, or just keeping certain hospitals afloat.

Maybe the single worst argument for inflated GME funding is that GME-dictated patterns of care drive up direct patient care costs.

In a system that is trying to get its costs under control, can we accept that the environment in which we train future doctors itself causes inefficiencies? That's no more acceptable than asserting that we should accept poor quality or lack of safety as a price of GME. We got past that a long time ago.

Do you see the risks this continued mislabeling or worse poses to the survival of GME programs themselves?

I am particularly concerned when the non-GME interests and needs piled on GME distort and threaten the GME mission itself.

If, as we heard earlier this year, the continued flow of GME dollars is essential for institutional survival, at least in the downstate environment, we have forced upon virtually every institution a business necessity of maintaining GME programs regardless of whether they serve a proper GME purpose.

GME's champions point to the great academic medical centers and to fine community teaching hospitals. These are characterized by strong faculties, breadth and depth of training programs, significant research and, generally, the ability to devote adequate resources to GME and to place education on at least an equal footing with patient care service. Leaving aside their success at achieving other public goods, they provide marvelous graduate medical education experiences.

Does this hold true across the entire spectrum of GME in New York? If GME-related funding is an essential lifeline for almost every hospital, we have in fact mandated that small, struggling, poorly staffed and poorly performing hospitals will rely in desperation on any residency program for which they can maintain accreditation.

They will recruit residents wherever they can find them, emphasize patient care duties over education, and teeter along the edges of supervision, safety and discipline.

Such programs, rather than serving as a pipeline to solve current and future workforce issues, probably constitute a kind of professional workforce black hole. Bear in mind that this is occurring in communities with some of the highest levels of unmet need. Decades of supporting GME programs and the production of hundreds of graduating residents have not made much of a dent.

Solutions to community primary care quality and access problems would actually reduce demands for the emergency, Article 28 clinic and inpatient services on which these hospitals and their residency programs depend.

A strong case can be made by this Council and many institutions for preserving what is best about GME as it is conducted in our university and independent academic centers and in some community hospitals.

I believe that in a second case we must be willing to honestly examine GME programs at the other end of the spectrum of mission and quality. I do not believe the medical education leaders who are anxious to defend the first case, can recuse themselves from the second case. And I do not believe we can rely on the ACGME and AOA to show more backbone than we do.

One of the important tasks of my new position is implementing the requirements of the Berger Commission. In case some of you have been personally scoring in the low single digits on the Glasgow Coma Scale, Berger mandates a modest reduction and restructuring of New York's hospital (and long term care) industry.

We are proceeding along those lines with success. But it is remarkable to me how many hospitals and systems are resisting these and other changes. Frequently they cite their need to maintain GME programs as if residencies and fellowships should be a starting point for health services planning rather than carefully considered finishing touches to a healthy system.

Objections of any kind are almost always offered with the proviso that Berger got it right everywhere else, just not in their case.

I told Steve Berger several months ago that he'd done a brilliant job. His team had somehow found and identified by misdirection 9 indispensable hospitals which, if kept open at all costs, would solve New York's problems.

Berger and other restructurings underway have an essential relationship to the GME dilemma. After implementation, we will have a leaner, stronger hospital system. It will be more rationally organized and on financial underpinnings that will not require excessive reliance on GME funding. Just as this Council and our major systems and academic centers must engage on the evaluation of the mission and quality of all GME programs, we need support, not reflexive resistance, in restructuring the entire system -- not just those parts that only affect "the other guy."

I'll repeat what I said about physician supply: If "GME-maximizing" reimbursement streams and strategies were the proper solution to their financial problems, New York would already be Shangri La for hospitals.

Third, I am unconvinced by the arguments made for disproportionately large GME expenditures and GME programs as independent economic drivers and therefore niches or sectors to be maximized on their own merits I am not an economist, and I do not play one on TV, but let me make a few comments.

It goes back to the Detroit analogy I found so worrisome. You've heard the wry comment that the auto industry is a money-losing health care enterprise that conducts a manufacturing business on the side as a partial subsidy.

Supporting a disproportionately large and misconfigured GME industry on a weak hospital base because of the supposed beneficial economic impact of GME would be a Detroit style and size folly for New York hospitals, businesses and taxpayers.

GME should be sized, configured and reimbursed around its **core mission** – attracting, training and launching into New York the physicians needed to serve our citizens and support some New York institutions as clinical and biomedical research leaders.

The legitimate financial difficulties of well managed hospitals, the problems of staffing hospitals, the need to provide care for low income patients with state and federal coverage, and to fund indigent care until we reach near universal coverage are best considered relatively independently of GME.

What residents in training and their faculty and teaching hospitals spend in their communities is welcome. However, to the degree their services meet real needs in an efficient manner, they or others serving those needs will remain, be supported and spend in the same communities, often making deeper and longer term commitments than those produced by reliance on GME.

Expenditures on health care above those efficient levels cannot make economic sense in the long run and employers and taxpayers already know that.

We are often reminded of "the Federal Medicaid match" in discussions about GME. The match is not a secret known only to New Yorkers. Should it drive us to dependence on GME and make our other health care planning and finance decisions for us?

Deborah Bachrach, who runs our Office of Health Insurance Programs, returned from a meeting of state Medicaid directors where she had an opportunity to speak with colleagues from California. They observed with some wonder that New York apparently always looks at what getting the federal match "earns" it. California looks at what the match "costs."

The amounts, of course, are equal – roughly 50 cents on the dollar either way. The only valid standard for what we should do under the Medicaid umbrella, including GME, is whether the services are necessary, delivered in a cost-effective and compassionate manner, and whether they achieve the desired outcomes.

GME programs that contribute effectively are welcome; those that don't are not sustainable despite the match. Playing the match any other way is like the fallacy of sneaking food off your spouse's plate – you get just as fat and you still have to pay for the food and do the dishes.

If disproportionate reliance on GME were an effective local economic driver, our inner city hospital neighborhoods would already be lands of milk and honey.

Fourth, I am troubled by the positive relationship that some draw between New York's reliance on GME and success in biomedical research. This is not borne out by the facts.

Soon after becoming commissioner and in the middle of the budget process, I met with a number of deans of medical schools. I'm quite certain I heard them say that any state cuts in GME funding would immediately and substantially cut into their ability to compete and succeed at biomedical research.

I reminded them of the meticulous attention hospitals must make to ensure that there will be no mingling of funds dedicated to patient care or resident training with research funding, and that the NIH applies the same rigorous standard in reverse.

Using NIH funding as a measure, New York's position in biomedical research has been declining over the very years in which our peculiar attraction to graduate medical education has been advancing. I will not go over those numbers as they are probably depressingly familiar to many of you.

I challenge anyone to look at the institution by institution distribution and cost of GME programs in New York, and in particular the per resident amounts paid, and demonstrate a correlation with institutional commitment to research. Many institutions receiving large total and high per resident amounts have no or very little research to show for it.

Must we support GME programs of every stripe everywhere as the price for the variable and uncorrelated research competitiveness of a subset of institutions?

If emphasis on GME, in the New York mode, were the key to success in the research world, New York would already be the Promised Land.

I've outlined four areas of concern:

- GME's unhappy relationship with physician supply problems
- Hospital finances made overly dependent on funding labeled GME

- Excessive GME spending threatening to turn us into a health care Detroit
- Depending on GME for a renaissance in New York's research leadership

In no way wish do I wish to represent that I have all the answers or even have asked all the appropriate questions. I sometimes feel that I spent the first three months in this position just learning about all the things I don't know.

I've tried to get around to see many of you, in particular in less formal settings where we can exchange ideas and learn from each other. I hope to do more of this as we address these issues.

I can point to a number of initiatives already underway to clarify and address some of these concerns. To ensure that New Yorkers receive affordable, high-quality care that improves health status, New York State is currently examining the way the State pays for health care, the value of what it is purchasing, and the most efficient healthcare structure.

- We are implementing and investing in the Berger mandates and other hospital restructuring efforts without which no amount of GME-based subsidies will suffice.
- We are reforming Medicaid and Medicaid-linked inpatient payment rates by updating service intensity weights. This sounds technical but is far reaching and long overdue. If we get it right, I'll go somewhere to mediate between merger partners and find them fighting over which one corners obstetrical services and which one is stuck with the cardiac catheterization lab.
- We are studying the indigent care payment system and may well recommend sweeping reforms which will in turn impact on how we regard GME. Maybe we can end the identity theft the industry uncovered last February.
- We have a brilliant team analyzing ambulatory care reimbursement rates and mechanisms. Upward adjustment and implementation of better performance and outcome incentives may reduce the reliance on medical residents to provide primary care to Medicaid recipients. It may also move larger numbers of residents into environments likely to attract them into long-term commitments and better serve patients.
- We are undertaking the sweeping health care information technology transformation necessary to support these and other changes.
- New York State has greatly expanded its direct support of biomedical research with the stem cell initiative.

As part of this, the State will be looking at New York's huge investment in GME and will ask:

- Is this what we want to buy?
- Is this the right way to buy it?
- Are we paying the right price to the right parties?
- Is what we are buying producing the expected results?

I'm hoping that this Council can help us with some of the answers.

Today I'd also like to leave you with one specific proposal. I would like to recommend a concrete step to address the language gap between physicians-in-training and practice and the needs of many of our most underserved populations.

I appreciate the length of the physician workforce pipeline and the strict academic demands at every point of entry and narrowing. At the branching distal end of the pipeline, the attractions into various career pathways are created by forces largely beyond the influence of our undergraduate and graduate medical education establishments.

As I am sure you are, I am impressed at the quality and drive of students attracted to medical careers today. Medicine is often a preferred career choice of aspiring second generation and later Americans and of the children of today's physicians.

This produces terrific applicants and an almost pre-ordained mismatch with the cultures and languages of the latest immigrants and the marginalized. Today's most prominently new immigrants in New York City may be rural Mexicans. By the time their children or grandchildren apply to medical school -- and they will -- the immigrants will be from somewhere else.

I believe there is a way to use the length of the pipeline and the consistent attractiveness of medical careers to address the language gap.

I'm aware of many well intentioned but largely unsuccessful attempts to introduce formal language training into the residency years. We appropriately limit resident work weeks to 80 hours and pack those hours with the maximum sustainable amount of service and didactics. Additional off-duty hours are spent studying.

It is unreasonable to think we will successfully shoehorn in, in particular in the early years of training, 500 to 600 hours of total immersion followed by the daily practice necessary for a good start in a new language. At best we teach courtesies and a few phrases. And at worst perhaps breed dangerous overconfidence.

This must hold true for the medical school years. I hear almost every week of some passionate advocacy for adding or enlarging some part of the medical school curriculum – more geriatrics, nutrition, pain medicine, health systems, ethics, genomics, informatics, complementary medicine. I don't recall anyone suggesting something that could be cut to make room for successful language training.

Suppose, instead, that this Council agreed with our medical and osteopathic schools to jointly support a simple requirement: that applicants for medical school in New York -- beginning several years from now -- would have to demonstrate satisfactory verbal and written fluency in a modern, non-English language. As those graduates applied for residencies, GME programs would begin to require and rate second language proficiency as a key match requirement.

Would prospective applicants meet the requirement? Of course they would. We all know medical school applicants would do anything to get in. If we mandated that they come out of college able to run a five-minute mile while reciting *Moby Dick*, they would do it.

Every college and university offers language training. Many students will probably figure out a way to combine language study with enjoyable study abroad or a stint building community centers in Guatemala.

Applicants with native fluency in another language would be rewarded with additional time to improve on their other academic achievements while their gringo competitors struggled to learn a new language. If this produced a change in the slope of the playing field for medical school acceptances and later for residency matching, great! Competitive residencies and fellowships would have nothing to fear nor would international graduates.

Prospective medical students would probably naturally distribute themselves across future linguistic needs. Some would choose Spanish because of its everyday utility and ease of acquisition. Others would take up Chinese with an eye on the global economy. The literary inclined might pick Russian more out of interest in Pushkin than medicine, while someone else would learn American Sign Language because of a family member.

Maybe admissions committees would look to balance second language capabilities just as they now balance other class characteristics.

As second language-fluent medical students, then residents, worked their way through the pipeline, I have little doubt that they would be both more attracted to

careers in currently underserved communities and more attractive to the patients and institutions of those communities.

Coming back to Pushkin, how many medical school requirements serve a practical need and enrich the applicant's life at the same time?

I did just fine at inorganic chemistry but can't really say that it's made my life better beyond helping me get into medical school. My father learned Latin for medical school. I don't think he's used it since 1946.

My generation and that of my son's evaded any language requirement for medical school. I don't think that is right for the wonderful New York melting pot or for the global economy.

This would be a practical and mutually rewarding demonstration of our professional and institutional commitment to better serve our communities.

I've raised a number of questions and concerns today about New York's GME program.

I'd like to start a dialogue with you on principles and strategy and hear from you on the points I've raised today. So, please, let me hear your thoughts. Additionally, over the summer I will be looking for opportunities to meet with the deans, the chairs of GME programs, and other stakeholders.

Appendix B

National Association of State Medicaid Directors Survey Graduate Medical Education: Select State Medicaid Payment Policies

August 9, 2007

During July of 2007 the National Association of State Medicaid Directors (NASMD) conducted a survey on Graduate Medical Education (GME) to explore the details of Medicaid Agencies that fund this cost. Many states choose to fund GME through their Medicaid Agencies or through other means in order to support the professional development of qualified physicians in their state. This survey explores which states fund GME through Medicaid, which fund it through other means, the rationale for doing or not doing so, and funding formulas and language. As of August 3, 2007, 24 states and territories responded to the survey (for simplification, the District of Columbia and the Commonwealth of Puerto Rico are referred to as states throughout the rest of this document). These states are: Alaska, Arizona, Arkansas, Delaware, the District of Columbia, Florida, Georgia, Idaho, Iowa, Maryland, Massachusetts, Minnesota, Nebraska, Nevada, New Jersey, Puerto Rico, Rhode Island, South Dakota, Tennessee, Texas, Vermont, Washington, Wisconsin, and Wyoming. The following report provides an analysis of the responses received. Additionally, there is an appendix attached to this document which provides excerpts from several Medicaid State Plans that contain the formula(s) that GME reimbursement is based on.

Medicaid Paying for GME

1. Through Medicaid, does your State pay for GME costs?

Twenty one State Medicaid Agencies pay for GME costs. The Medicaid Agencies reimburse many different institutions for their GME costs. Ten of the states pay to more than one institution. The number of states that pay for GME costs at each institution and the state abbreviations follow.

- Teaching hospitals: 19 states (AZ, AR, DE, DC, FL, GA, IA, MD, MA, MN, NE, NV, NJ, SD, TN, TX, WA, WI, WY)
- Acute (non-teaching) hospitals: 10 states (AK, AZ, AR, DE, DC, FL, ID, MA, MN, WY)
- Medical schools: TN

- Non-hospital ambulatory sites: 2 states (MN, WY)

Two states also reimburse GME costs to institutions other than those above; these include nursing homes and pharmacies (Minnesota) and teaching sites in other hospital settings (Nebraska).

Three State Medicaid Agencies do not pay for GME costs; these states are the Commonwealth of Puerto Rico, Rhode Island, and Vermont. Puerto Rico did not provide reasoning for not covering GME costs. Rhode Island explained that GME costs are included in their disproportionate share hospital (DSH) payment plan, therefore their State pays for GME, but not through Medicaid. Vermont commented that they are doing payment restructuring this year, so they may begin paying for GME but currently they do not do so. Since the rest of this survey is about states that do pay for GME, these three states are not included in the rest of the questions.

GME Reimbursement Methodology and Formulas

2. Through Medicaid, does your State follow the Medicare methodology for GME reimbursement? If yes, does your State use current data? Explain:

Out of the 21 states that pay for GME, 9 states reported that they use the Medicare methodology to determine their GME reimbursement. These states are Delaware, District of Columbia, Florida, Idaho, Maryland, Nebraska, Nevada, Texas, and Wisconsin. Of these nine, eight provided us additional information about the type of data used in this Medicare Methodology (see Table 1 below). The other 12 states do not use the Medicare Reimbursement Methodology to determine their GME reimbursement.

Table 1. Data States Use for Medicare Reimbursement Methodology

State	Data for Medicare Reimbursement Methodology
Delaware	Based on actual resident costs and has been indexed forward along with the hospital's costs.
Florida	Uses the Medicare cost report for IP and OP regular Medicaid reimbursement. We have a category in our DSH program called GME DSH that provides for DSH payments to hospitals meeting

	certain criteria as provided for in our state plan.
Idaho	Based on resident count caps.
Maryland	Based on percentage of teaching hospitals rates representing GME Costs. These costs are based on historic cost and discharge data per HSCRC.
Nebraska	Based on Medicare FY 1997 data that are adjusted annually by the Market Basket Index (MBI).
Nevada	Based on the total full time equivalent (FTE) using data from each qualifying hospital. The data is from the most current available audited Medicare cost report as of April 1 st of each year.
Texas	Based on current data as reported on the providers annual cost report for Medicare.
Wisconsin	Based on the most current available data for Medicare.

3. What process or methodology does your State use to fund GME costs?

Twenty one states indicated one of the following methods as the one(s) they use to determine their GME reimbursement. Many states indicated use of more than one methodology. The number of states and state abbreviations are indicated after the method.

- Per resident amount: 6 states (AZ, ID, NE, NJ, SD, TX)
- Lump sum amount: 6 states (DE, FL, GA, MN, NJ, TN)
- Amount based on Medicaid revenue/patient volume: 8 states (AK, AZ, DC, FL, MN, NV, NJ, SD)
- Annual Appropriations: 9 states (AR, AZ, FL, IA, NV, SD, TX, WI, WY)
- Hospital payment rate per discharge: 3 states (MD, MA, NE)
- Diagnosis-related group (DRG): 2 states (GA, WA)

The two additional methods that states provided are: (1) Minnesota also includes inpatient hospital rates; (2) Nevada also includes a Medicaid full time equivalent (FTE) calculation.

4. How is the payment determined?

Of the 21 states that pay for GME through Medicaid, 20 states indicated the factors that their GME payment formula is based on. Eight states responded that multiple factors determine their payment amounts. The following factors were reported as determining their GME payment amount:

- Fixed amount: 3 states (AZ, NE, TX)
- Historical GME costs incurred by hospital: 7 states (AK, DE, GA, FL, MN, TX, WY)
- Hospital share of Medicaid revenue/volume: 6 states (AK, AZ, MN, NE, SD, WI)

Eleven states also indicated factors other than those above that determine their GME payment (see Table 2 below).

Table 2. Other Factors Determining GME Payment Formula

State	Other Factor(s) Included in Formula
Arkansas	For teaching hospitals: hospital cost report; for acute (non-teaching) hospitals: maximum per diem cost limit of \$850 per day.
District of Columbia	DRG payments
Idaho	Hospital Share of Medicaid Days
Iowa	Amount of medical education costs of each qualifying hospital, divided by medical education costs of all qualifying hospitals, multiplied by the medical education allotment.
Massachusetts	Cost based pass through amount
Minnesota	Hospital cost and Medicaid volume

Nebraska	Average cost per discharge for approved intern and resident programs, which is based on the percentage of Medicaid patient days to total patient days in the base-year.
Nevada	Medicaid full time equivalent (FTE) calculation
New Jersey	Resident FTEs weighted by Medicaid utilization
Tennessee	Fixed amount per waiver
Wyoming	Percentage of operating costs for hospital services

5. Is there a cap on Medicaid reimbursement for GME in your State? If yes, what is the basis for the cap?

Eight states indicated that they have a cap on their Medicaid reimbursement for GME. The following explanations were given as the basis for the cap:

- 4 states have their payments capped at the amount the state appropriates for GME. These states are Nevada, South Dakota, Arizona, and Texas.
- 2 states, New Jersey and Iowa, have their payments capped at an upper limit. New Jersey's upper limit is set at the combined DSH and GME payment that the institution received in 1997. Iowa's upper limit is set at historical medical education costs that are adjusted for inflation.
- Tennessee's cap is negotiated in its waivers.
- Minnesota has a situation where they have a portion of the funding capped based on appropriated funds, but the other portion is uncapped (this state was counted as one of the 9 states with a cap).

Ten states indicated that they do not have a cap on their Medicaid reimbursement for GME. Maryland and Washington did not answer this question.

One state, Wisconsin, answered both yes and no and has not been included in the above totals of state with and without caps. Wisconsin did indicate that they have limited payments based on the amount appropriated each year (this seems to essentially be a fluctuating cap).

6. Does your State reimburse for GME based on: costs, add on to reimbursement rates, patient volume, specific pools, or other?

Twenty states indicated what formula components their reimbursements for GME costs were based on. Maryland did not answer this question. Several states chose more than one formula component.

- Costs: 11 states (AR, AK, AZ, DE, FL, GA, ID, IA, MA, MN, TX)
- Add on to reimbursement rates: 7 states (AK, DE, DC, GA, NE, WA, WY)
- Specific pools: New Jersey

Six states indicated that they reimburse for GME based on components other than these (see Table 3 below).

Table 3. Other Formula Components to GME Reimbursements

State	Additional Formula Component(s)
Arizona	An incentive for rural rotations
Georgia	Costs of care management organizations (CMOs) and DRG add-on payments
Minnesota	MERC (Medical Education and Research Costs) funding formula
Nevada	Medicaid full time equivalent (FTE) calculation
South Dakota	Weighted average of interns/residents in primary care and number of Medicaid inpatient days
Tennessee	Lump sum divided based on resident counts

Please explain your Medicaid GME payment methodology:

7. Does your State use a pooling approach to fund GME?

Fourteen states do not use a pooling approach to fund GME. Two states, Arizona and Minnesota, do use pools. Arizona uses two pools of funds: the first is for those GME programs and residency slots that have been in place since 1998 are in one

pool to protect their historical allocation of GME funds; the second pool is for new GME programs and residency expansions that occurred after June 2006. Minnesota uses a pool called MERC which pools state tobacco tax revenue, Medicaid managed care rate carve-outs, and federal matching funds.

Other State Funding Sources for GME

8. Does your State provide funding sources other than Medicaid to support GME? If yes, provide an explanation of the funding sources.

Four states provide funding other than Medicaid to support GME. These states are Minnesota, Texas, Alaska, and Tennessee. In Minnesota, beginning in SFY 2008, state-only grant funds will go to low Medicaid volume teaching hospitals. Alaska also contributes general state funds that are appropriate to GME. Tennessee also has a state match to draw down the Medicaid FFP. The Texas legislature appropriates additional general state funds for some state fiscal years.

Fifteen states do not provide funding other than Medicaid to support GME.

Total State Funding for GME

9. Identify payments made for GME from all State sources for the latest State fiscal year:

Fourteen states were able to provide the total amount of state funding provided for GME. The states provided this information for various fiscal years (FY) including FYs 2006, 2007, and 2008. The following chart indicates the appropriated amount and fiscal year and is organized by fiscal year.

Table 4. Total State Funding for GME

State	Amount Appropriated	State Fiscal Year
Delaware	\$ 817,603	2006
Florida	\$249,206,452	2006
Idaho	\$ 200,000	2006

Massachusetts	\$43,600,000	2006
Minnesota	\$68,200,000	2006
Tennessee	\$18,022,100	2006
Texas	\$1,800,000	2006
Wyoming	\$209,846	2006
Arizona	\$ 31,147,499	2007
Nebraska	\$8,053,112	2007
Nevada	\$ 362,249	2007
South Dakota	\$2,400,000	2007
Alaska	\$2,000,000	2008
Iowa	\$ 26,473,933	No FY given

Note: all of these dollar amounts are estimates.

Total State Medicaid Funding for GME

10. Identify Medicaid payments made for GME for latest State fiscal year:

Fifteen states provided the total funding that their State Medicaid Agencies paid for GME. The states provided this information for various fiscal years including FYs 2006, 2007, and 2008. The following chart indicates the appropriated amount and the fiscal year.

Table 5. State Medicaid Funding for GME

State	Amount Appropriated	State Fiscal Year
Delaware	\$ 817,603*	2006
Florida	\$ 74,999,083	2006
Idaho	\$ 200,000*	2006

Massachusetts	\$43,600,000*	2006
Minnesota	\$65,200,000	2006
Tennessee	\$ 31,977,900	2006
Texas	\$0	2006
Wyoming	\$209,846*	2006
Arkansas	\$5,673,289	2007
Arizona	\$ 31,147,499*	2007
Nebraska	\$8,053,112*	2007
Nevada	\$ 820,429	2007
South Dakota	\$2,400,000*	2007
Alaska	\$800,000	2008
Iowa	\$ 26,473,933	No FY given

Note: all of these dollar amounts are estimates.

*Same as amount in Table 3 because the state does not give funding to GME other than through Medicaid.

State Plan Language on GME Reimbursement Methodology

11. Can you share with us your approved Medicare State Plan provisions that describe the GME payment methodology?

Eight states have openly shared their approved state plans with provisions that describe the GME payment methodology. These states are Arkansas, Florida, Georgia, Iowa, Nebraska, Nevada, Texas, and Wyoming. For the details about this information see Appendix 1.

Appendix C

The Role of Accrediting Bodies in Promoting Quality of GME

GME in New York, like the rest of the country, is subject to accreditation oversight that serves to set standards for the field and promote quality. Accreditation of teaching institutions and residency programs by a national organization is technically voluntary, but because so much of the needed funding (e.g., Medicare and Medicaid GME funding) that teaching hospitals depend on for their operation and for their educational activities is dependent on this status, accreditation by one of these national organizations is all but required in order to be operational.

The ACGME

The Accreditation Council for Graduate Medical Education (ACGME) is the principal accrediting body for physician residency training in the U.S. The ACGME is a private, non-profit organization, the mission of which is to improve health care by assessing and advancing the quality of resident physicians' education through accreditation. The ACGME is the accrediting body for the residency and fellowship training of allopathic physicians. The ACGME's member organizations are the American Board of Medical Specialties, American Hospital Association, American Medical Association, Association of American Medical Colleges, and the Council of Medical Specialty Societies. Member organizations each appoint four members to the Board of Directors, which also includes two resident members, three public directors, the chair of the Council of Review Committee Chairs and a non-voting federal representative.

In academic year 2005-06, there were 8,186 ACGME-accredited residency programs in 120 specialties and subspecialties. The number of active full-time and part-time residents for academic year 2005-06 under the jurisdiction of the ACGME was 103,367. The ACGME has 28 review committees (one for each of the 26 specialties, one for a special one-year transitional-year general clinical program, and one for institutional review). Each residency committee comprises up to 15 volunteer physicians.

Other Major Accrediting Bodies

There are three other major accrediting bodies upon which the Federal government principally relies to ensure that Medicare GME reimbursement is supporting a qualified professional training program. The American Osteopathic Association (AOA) is the accrediting body for the internship and residency training of osteopathic physicians.¹ The AOA through its Program & Trainee Review Committee approves postdoctoral training programs, determines program eligibility requirements, and evaluates interns and residents as well as the postdoctoral programs. The American Dental Association's (ADA's) Commission on Dental Accreditation establishes, maintains, and applies standards that ensure the quality and continuous improvement of dental and dental-related education and reflects the evolving practice of dentistry. The Council on Podiatric Medical Education (CPME) is an autonomous accrediting agency for podiatric medical education. Deriving its authority from the American Podiatric Medical Association, this Council is empowered to develop and adopt standards and policies as necessary for the implementation of all aspects of its accreditation, approval, and recognition purview. The CPME has final authority for the accreditation of colleges of podiatric medicine, the approval of residency programs and sponsors of continuing education, and the recognition of specialty certifying boards for podiatric medical practice. All of these accrediting organizations develop standards that institutions and residency programs must meet in order to maintain their status (and receive funding that is dependent on that status).

In the case of physician residency and fellowship training that is subject to accreditation, there are two tiers of accreditation – the institutional tier and the residency program tier. Both must be maintained in order for the residents training in the relevant program to be considered board-eligible upon program completion.

Institutional Requirements As A Promoter of Quality

Institutional accreditation for physician residency training focuses on the teaching organizations that officially “sponsor” physician residency programs. Sponsorship involves assuming the main administrative responsibilities for physician residency programs, including oversight of individual program accreditation. Institutional

¹ There are fellowship-level physician training programs that are not eligible for accreditation that are nonetheless eligible for GME reimbursement. Such programs must meet the fundamental “test” for the Federal government: (1) lead to separate certification; and (2) be approved by a nationally recognized organization (i.e., specialty boards).

accreditation may be granted to a teaching hospital, a medical school, another healthcare organization, or a consortium consisting of some combination of the above.

Institutional Standards

The institutional sponsor of the residency programs must meet a set of institutional standards developed by the ACGME. Among the standards that the teaching institution must meet are to have an institutional GME Committee (GMEC) and a “designated institutional official” (DIO) that together present an annual report to the sponsoring organization and all participating institutions that summarizes the institution’s activities in the past year with regard to monitoring resident supervision, evaluation, and other areas of common concern. The DIO must also ensure that the teaching institution has current affiliation agreements with all of its major affiliates in which the scope of experience to be gained at each affiliated organization is clear.

At an institutional level, the Joint Commission for the Accreditation of Healthcare Organizations requires the DIO to monitor and improve quality measures in the residency programs. The annual report mentioned above must address several issues, such as the residents’ role in patient safety and quality improvement at the institution.

Each sponsoring entity submits an Institutional Review Document (IRD) that answers several specific questions regarding institutional oversight of GME at their own and participating sites. Documentation is collected to support the IRD in preparation for the institutional site visit. The process is similar to individual residency program accreditation as described below. However, institutional commitment and support is considered essential to maintaining accreditation as a sponsor of GME programs.

Teaching Institutions’ Roles as Sponsors and Training Sites

Not all teaching institutions that train physician residents serve as sponsors of physician residency programs. In some cases, a hospital may act as the training site for physician residents in certain specialties but not serve as the official sponsor of a particular residency program or any residency programs. This role as the training site is facilitated by an official academic affiliation between the sponsoring organization of the residency program and the training site. An individual teaching

hospital can serve both as an official sponsor and training site for a set of physician residency programs and also as a training site for physician residency programs sponsored by other teaching institutions. That is, at any given time, a teaching hospital may be training physician residents from “its own” (sponsored) programs and physician residents from one or more other teaching institutions’ sponsored programs.

Teaching institutions that sponsor residency programs enter into academic affiliations with other organizations, including other teaching hospitals, in order to promote the quality of the experience for their physician residents and to ensure that the residents gain the experience they need as defined by the individual specialty program in which the resident is training. Because accreditation requirements for particular specialties can be quite extensive and mandate a varied mix of patients and experiences in order to ensure a quality education, teaching institutions often find it necessary and mutually beneficial to enter into academic affiliations with other organizations for specific residency programs.

Program Requirements as a Promoter of Quality

In addition to overall institutional requirements, each physician residency program is subject to a set of separate accreditation requirements that is developed by experts in the field for that particular specialty. These experts collectively comprise the residency review committee (RRC) that oversees the requirements for that specialty.

Designation of Individuals to Monitor Standards

The ACGME relies on “appointing organizations” to designate members of particular RRCs. The individuals appointed to the RRC are subject to approval by the ACGME Board of Directors. For example, there is a specific RRC for neurological surgery and the appointing organizations are the American College of Surgeons, the American Board of Neurological Surgery, and the American Medical Association. These organizations appoint the members of the RRC that oversee the standards for every neurological surgery residency program in the country accredited by the ACGME. This process serves to ensure that the specific requirements for training in that specialty promote learning in the current practices in that specialty.

Program Standards

Individual specialty requirements are consistently being updated as a result of new advances in the delivery of care. For example, if a new product or technique is developed and validated in the particular field such that the experts overseeing the requirements for training in that specialty believe it to now be an essential part of the specialist training, the specialty program requirements will be amended to mandate experience in that technique as an essential part of the training.

Because teaching hospitals and physician residency programs are subject to regular reviews and site visits as part of the overall accreditation process, it is imperative for these organizations to be constantly updating their curricula and educational methods to ensure that these new standards are being met.

The ACGME Outcome Project as a Means to Promote Quality

As part of an effort to promote quality in the training of residents, and to create a more well-rounded and outcome-based curriculum, the ACGME established its Outcome Project in the mid-1990s. The goal of the Outcome Project is to gradually increase outcome assessment in the accreditation process for residency training. The ACGME has stated that given the complexity of quality assessment in the area of GME, it views the Outcome Project as a long-term initiative.

The General Competencies

To date, the Outcome Project has focused principally on the incorporation of a set of developed general competencies into the program requirements of the core specialties. Under the Outcome Project, graduates of residency programs are expected to have been demonstrated competence in the domains of (1) patient care; (2) medical knowledge; (3) practice-based learning and improvement; (4) interpersonal and communication skills; (5) professionalism; and (6) systems-based practice.

As part of the Outcome Project, residency programs are required to develop and implement a plan to evaluate their trainees along these six domains. This evaluation program must include a mechanism for providing regular and timely feedback to the residents. The residency programs are also expected to use resident performance and outcome effectiveness in the evaluation of the residency program itself.

Timeline of the Outcome Project

The ACGME is currently in Phase 3 of the Outcome Project. This phase, which is expected to continue through 2011, is focused on integrating the competencies and their assessment into the learning model and the delivery of clinical care. During this phase, residency programs will be expected to use external indicators to help to assess the performance of the residents and the programs in which they trained.

Monitoring of Compliance with Quality Standards

The ACGME uses a variety of mechanisms to ensure that residency programs and teaching institutions are able to comply with the organization's standards. The ACGME and the American Board of Medical Specialties (ABMS) are collaborating to improve the evaluation of residents during their residency education programs. The Toolbox of Assessment Methods was the first product of this joint initiative. It provides a brief description of 13 assessment methods and references to articles where more complete and in-depth information about each method can be found. The Toolbox will be revised periodically to reflect the ongoing work of the joint initiative.

Program Information Form

Each residency program accredited by the ACGME is required to complete a "program information form" (PIF) in preparation for a site visit. The PIF is the source document for key information about the residency program and is used by the RRC and the program's site visitor to ensure compliance with ACGME and individual RRC standards.

The PIF includes two parts: (1) Information regarding compliance with the ACGME's Common Program Requirements is provided via the Accreditation Data System, and (2) information regarding compliance with the particular RRC's program requirements are also completed and form the source document for the site reviewer's visit to the program.

Internal Reviews

Every accredited residency program, as well as the teaching institution itself, is expected to conduct a regular internal review at the midpoint between its

accreditation site visits as part of its quality assurance program. An internal review is essentially a formal self-evaluation process to ensure that the teaching institution or the residency program is in substantial compliance with the standards as set forth by the accrediting organization. The main purpose of the internal review is to monitor and improve program quality at a time other than that of the site visit. After each internal review is conducted, a report is generated, listing “future goals recommended” for program improvement. These are essentially internal “citations”, promulgated under a peer-review process conducted for the program’s benefit. The internal review is the single most important mechanism that the institution’s GME Committee has at its disposal to monitor and ensure the quality of its residency programs.

Site Visits

Each year, the RRCs review nearly one-half of all accredited programs. Approximately 2,000 of these reviews involve a formal on-site visit to the program; the remainder is based on documents the programs provide to the ACGME. On average, each accredited residency program is site visited every three and a half years. Intervals between site visits range from one to five years. A longer period generally indicates that the ACGME and RRCs are more confident about a program’s ability to provide quality education.

The formal periodic review of programs involves an on-site inspection and is based on the PIF. Site visits are conducted either by a member of the ACGME field staff or by a Specialist Site Visitor, volunteer experts who conduct a small number of site visits in their specialty during a given year. The site visitor is not the decision-maker regarding quality of a given educational program. The site visitor is a fact-finder, whose role is to verify and clarify the information provided in the PIF by interviewing residents, faculty and program leadership. Importantly, each site visitor also interviews the DIO.

The PIF and the site visitor’s report form the basis of the RRC’s review and accreditation decision. The site visit consists of interviews with the program director, members of the teaching faculty, resident physicians, and often administrators and other key personnel. Following the visit, the site visitor composes an objective narrative report of the information he/she collected during the interviews. This document is factual and nonjudgmental, and reports omissions or discrepancies between the PIF and the information collected during the interviews. These reports present the information gathered at the visit, without any effort to sway the RRC for or against the program.

Resident Surveys

Each year from mid-January through early June, the ACGME requires residents and fellows to complete an online survey. This survey contains questions about the resident's clinical and educational experience, as well as duty hours worked. Many RRCs have added specialty-specific questions and have started to amass a national database of this information, by specialty.

Assuming that at least 70 percent of the residents have completed the survey and that the program has at least four residents, summary reports for the program will be available through the ACGME's Accreditation Data System for the residency program director or the designated institutional official to review. Only summary data are displayed; no individual data are available.

The data from the survey are intended as a diagnostic tool to focus the ACGME's field staff's questions during the site visit and also shared for peer review at the GMEC meetings. The ACGME field staff member will use the aggregate data to focus the questions during the site visit and to verify and clarify the information from them. Field staff members probe and clarify the duty hour items and items with a substantial number of non-compliant responses. If the interviews with residents suggest that past problem areas suggested in the survey data have been corrected, the field staff member will document this in the report about the program.

All decisions about programs' compliance with standards rest entirely with the RRC upon a review of all program information.

Appendix D

Guidelines for Medical Residents as Primary and Specialty Care Providers

These guidelines were developed by the Council to establish standards for the involvement of primary care and specialty residents in Medicaid Managed Care Plans. The following objectives were used to develop these standards:

- the need to protect the rights/needs of patients and to provide a single standard of care for all patients, including commercially insured and Medicaid HMO/PHSP clients;
- the need to bring training program capacity to the aid of Medicaid recipients; and
- the need for residents training in to have experiences caring for people who receive Medicaid and the medically uninsured.

Primary Care

Managed Care Organizations (MCOs) may utilize Medical residents as participants (but not as designated 'primary care providers') in the care of enrollees as long as all of the following conditions are met:

- Residents are a part of patient care teams headed by fully licensed and MCO credentialed attending physicians serving patients in one or more training sites in an "up weighted" or "designated priority" residency program. Residents in a training program which was disapproved as a designated priority program solely due to the outcome measurement requirement for graduates may be eligible to participate in such patient care teams.
- Only the attending physicians and nurse practitioners on the training team, NOT RESIDENTS, may be credentialed to the MCO and may be empanelled with enrollees. Enrollees must be assigned an attending physician or nurse practitioner to act as their PCP, though residents on the team may perform all or many of the visits to the enrollee as long as the majority of these visits are under the direct supervision of the enrollee's designated PCP. Enrollees have the right to request care by their PCP in addition or instead of being seen by a resident.

- Residents may work with attending physicians and nurse practitioners to provide continuity of care to patients under the supervision of the patient's PCP. Patients must be made aware of the resident/attending relationship and be informed of their rights to be cared for directly by their PCP.
- Residents eligible to be involved in a continuity relationship with patients must be available at least 20 percent of the total training time in the continuity of care setting and no less than 10 percent of training time in any training year must be in the continuity setting and no fewer than 9 months a year must be spent in the continuity care setting.
- Residents meeting these criteria provide increased capacity for enrollment to their team according to the following formula:

PGY-1	300 per FTE
PGY-2	750 per FTE
PGY-3	1125 per FTE
PGY-4	1500 per FTE

- Only hours spent routinely scheduled for patient care in the continuity training site may count as providing capacity and are based on 1.0 FTE=40 hours.
- In order for a resident to provide continuity of care to an enrollee, both the resident and the attending PCP must have regular hours in the continuity site and must be scheduled to be in the site together the majority of the time.
- A preceptor/attending is required to be present a minimum of 16 hours of combined precepting and direct patient care in the primary care setting to be counted as a team supervising PCP and accept an increased number of enrollees based upon the residents working on his/her team. Time spent in patient care activities at other clinical sites or in other activities off-site is not counted toward this requirement.
- A 16-hour per week attending may have no more than 4 residents on their team. Attendings spending 24-hours per week inpatient care/supervisory activity at the continuity site can have 6 residents per team. Attendings spending 32-hours per week can have 8 residents on their team. Two or more attendings may join together to form a larger team as long as the ratio

of attending to residents does not exceed 1:4 and all attendings comply with the 16-hour minimum.

- Specialty consults must be performed or directly supervised by the MCO credentialed specialist. The specialist may be assisted by a resident or fellow.
- Responsibility for the care of the enrollee remains with the attending physician. All attending/resident teams must provide adequate continuity of care, 24-hour 7-day coverage and appointment and availability access that meets RFP standards.
- Residents who do not qualify to act as continuity providers as part of an attending/resident team may still participate in the episodic care of enrollees as long as that care is under the supervision of an attending physician credentialed to the MCO. Such residents will not add to the capacity of that attending to empanel enrollees, however.
- Nurse practitioners may not act as attending preceptors for resident physicians.

Specialty Care

Residents may participate in the specialty care of Medicaid managed care patients in all settings supervised by fully licensed and MCO credentialed specialty attending physicians.

- Only the attending physicians, not residents or fellows, may be credentialed by the MCO. Each attending must be credentialed by each MCO with which they will participate. Residents may perform all or many of the clinical services for the enrollee as long as these clinical services are under the supervision of an appropriately credentialed specialty physician. Even when residents are credentialed by their program in particular procedures, certifying their competence to perform and teach those procedures, the overall care of each enrollee remains the responsibility of the supervising MCO credentialed attending.
- It is understood that many enrollees will identify the resident as their specialty provider but the responsibility for all clinical decision-making remains with the attending physician of record.

- Enrollees must be given the name of the responsible attending physician in writing and be told how they may contact their attending physician or covering physician, if needed. This allows enrollees to assist in the communication between their primary care provider and specialty attending and enables them to reach the specialty attending if an emergency arises in the course of their care. Enrollees must be made aware of the resident/attending relationship and must have a right to be cared for directly by the responsible attending physician, if requested.
- Enrollees requiring ongoing specialty care must be cared for in a continuity setting. This requires the ability to make follow-up appointments with a particular resident/attending physician, or if that provider team is not available, with a member of the provider's coverage group in order to insure ongoing responsibility for the patient by his/her MCO credentialed specialist. The responsible specialist and his/her specialty coverage group must be identifiable to the patient as well as to the referring primary care provider.
- Attending specialists must be available for emergency consultation and care during non clinic hours. Emergency coverage may be provided by residents under adequate supervision. The attending or a member of the attending's coverage group must be available for telephone and/or in-person consultation when necessary.
- All training programs participating in Medicaid managed care must be accredited by the appropriate academic accrediting agency.
- All sites in which residents train must produce legible (preferably typewritten) consultation reports. Reports must be transmitted so they are received in a time frame consistent with the clinical condition of the patient, the urgency of the problem and the need for follow-up by the primary care physician. At a minimum, reports should be transmitted so that they are received no later than two weeks from the date of the specialty visit.
- Written reports are **required** at the time of initial consultation and again with the receipt of all major significant diagnostic information or changes in therapy. In addition, specialists must promptly report to the referring primary care physician any significant findings or urgent changes in therapy which All training sites must deliver the same standard of care to all patients irrespective of payor. Training sites must integrate the care of Medicaid, uninsured and private patients in the same settings.

Appendix E

DOH/Council - Graduate Medical Education Programs

- **GME Reform Incentive Pool** - Provides teaching hospitals and GME consortia with annual funding to promote State policy objectives in their institutions. These objectives include increasing: (1) the proportion of underrepresented minority (URM) resident physicians; (2) linkages with programs along the academic pipeline that are targeted for URM students; (3) the proportion of URM faculty in institutions; (4) training opportunities for residents in all specialties in ambulatory care sites, particularly in underserved communities or serving high-risk population groups; (5) cultural competence training for all residents; (6) reduction in subspecialty residents and programs; and (7) training in clinical research.
- **Designated Priority Program (DPP)** - Provides funding through Medicaid GME rates to teaching hospitals to support the training of residents in primary care programs. Programs in Internal Medicine, Pediatrics, Family Practice, Combined Medicine/Pediatrics and Obstetrics/Gynecology are eligible to apply for this designation. Programs must provide continuity of care to the same panel of patients throughout the three or four years of training. In addition, over one-half of all program graduates must be practicing in primary care after completing training in order for the residency program to maintain DPP status.
- **Minority Participation in Medical Education Grant Program** - Provides support to medical educators to encourage and support URM students to pursue careers in medicine and the health professions. Medical schools, a primary care residency program and a consortium of medical schools have received grant funding through this initiative. These funds have supported post-baccalaureate and summer research programs, tutoring and mentoring, admission and recruitment counseling, health career profession orientation, and faculty development.
- **Empire Clinical Research Investigator Program (ECRIP)** - Provides awards to teaching hospitals and GME consortia to train physicians in clinical research in order to advance biomedical research in New York's academic health centers. Awards are provided for one or two years for experienced researchers to mentor physicians in a specific clinical research project. This program should provide ECRIP fellows with the skills needed to apply as a co-

investigator for National Institutes of Health (NIH) funding or other private grant funds upon program completion.

- **Parent Partners in Health Education (PPHE)** - Provide technical assistance and evaluation for a pilot program administered by the Developmental Disabilities Planning Council (DDPC) to train residents to work with parents and service agencies that care for pediatric patients with disabilities. The ultimate goal of PPHE is to improve access to health care for individuals with developmental disabilities.
- **Medical School Participation in Ambulatory Care and School-Based Health Centers Grant Program** – Provides grant support to medical schools to train medical students and residents in ambulatory care settings and school-based health centers. Ten projects were funded at nine medical schools across the State beginning in July 2002. Projects provide training opportunities to medical students and residents for children who are economically disadvantaged. These health care experiences offer children direct access to young medical professionals who become excellent role models.
- **Insiders Tips: Navigating the Medical School Admissions Process** – The Council cosponsored a conference in October 2001 with the Associated Medical Schools of New York (AMSNY) - Minority Affairs Advisory Board and the New York Local Network (NYLAN) for pre-health advisors and individuals working with minority college students. Information was provided to: (1) dispel the myths and assumptions about the medical school admission process as it relates to minority students; (2) facilitate networking between minority affair officers and advisors; and (3) provide insight into cognitive and non-cognitive variables used in selection of minority students. The Council, AMSNY and the Mount Sinai School of Medicine convened a similar program in February 2008.
- **Increasing the Representation of Minorities in Medicine and the Health Professions: Policies, Partnerships and Outcomes** - The Council cosponsored a national conference in October 2000 with the Arthur Ashe Institute for Urban Health, AMSNY and the Biomedical Sciences Career Program at Harvard Medical School. This event included a review of several model pipeline programs designed to increase minority representation in medicine and the health professions. Panels also explored health and health care disparities among our citizens, affirmative action programs, cultural competency and provider training. United States Surgeon General David

Satcher, M.D. provided keynote remarks and cited the contributions New York has made in addressing the imbalance of minorities participating in medicine and the health professions.

Appendix F

Biographies of Council Members

John P. Naughton, M.D. (Chairman)

Interim Chairman of Rehabilitation Medicine and Professor of the Departments of Medicine, Physiology, Social & Preventive Medicine, and Rehabilitation Medicine at the State University of New York at Buffalo. He served as Dean of the University of Buffalo, School of Medicine and Biomedical Sciences for 21 years from 1976 through 1996. He received an A.A. from Cameron State University, a B.S. from St. Louis University, and an M.D. from the University of Oklahoma Medical Center. He completed a mixed internship at George Washington University, and an Internal Medicine residency at the University of Oklahoma Medical Center, followed by post-doctoral cardiovascular training. He is board eligible in Internal Medicine. He is V.P. of the James H. Cummings Foundation, Inc., was a member of the Board of Directors of the Erie County Council for the Prevention of Alcohol & Substance Abuse from 1998-2007. He has received numerous awards/honors and continues to be a member of various professional organizations. He has been an author on five books.

Charles N. Aswad, M.D.

Executive Vice President, Emeritus of the Medical Society of the State of New York, Former Chairman of the Council of the State University of New York at Binghamton and member of the Clinical Campus of Upstate Medical Center at Syracuse (Assistant Clinical Professor in the Dept of Family Medicine), Former Chair Dept. of Emergency Medicine at United Health Services at Lourdes Hospital in Binghamton, NY.

Peter R. Barra, M.D., F.A.C.P.

Medical Director and attending physician at Flushing Hospital and Medical Center and an attending physician at Long Island Jewish Medical Center and New York Hospital of Queens. He is a graduate of the University of Bologna Medical School in Bologna, Italy and completed his residency at the Veterans Administration Hospital in Northport, New York. He is presently board certified in internal medicine and geriatric medicine and is also a member of the private practice of the primary care internal medicine group Barra, Rawlings, Coman, MD, and LLP in Flushing, New York. Dr. Barra also works as a Medical Director and attending at Rego Park Nursing Home in Rego Park, New York. Dr. Barra has been a life-long resident of New York and has spent his entire professional medical career at New

York institutions. He is a member of the American Geriatrics Society, American College of Physicians and New York Academy of Medicine.

Roseanne C. Berger, M.D.

Senior Associate Dean for Graduate Medical Education at the University at Buffalo, Designated Institutional Official, and Associate Professor of Clinical Family Medicine & Pediatrics, Department of Family Medicine, School of Medicine & Biomedical Science. She is a graduate of Cornell University and New York Medical College. She completed her residency in Family Medicine at the University of California in San Diego and fellowship training in Geriatrics at the University at Buffalo. She is responsible for the oversight of 63 residency programs enrolling 750 residents. She is the past Chair of the Association of American Medical College's Group on Resident Affairs. She has administrative responsibility for GME, Continuing Medical Education and the UB Mini Medical School.

Neil S. Calman, M.D., A.B.F.P., F.A.A.F.P.

A founder of the Institute for Family Health (formerly the Institute for Urban Family Health) where he has served as President and CEO since its inception. He is Clinical Professor of Family Medicine at the Albert Einstein College of Medicine of Yeshiva University. He has been involved in the administration of community health facilities in medically underserved urban areas for the past thirty years. He is a practicing, board certified family physician, and sees patients at the Sidney Hillman Family Practice in Manhattan and the Walton Family Health Center in the Bronx. The Institute operates 17 federally qualified health centers, 2 family practice residency programs - one in New York City with Beth Israel Medical Center and one in Kingston with the Kingston Hospital and over 30 grant funded programs. Dr. Calman is a graduate of Rush Medical College in Chicago and completed his residency in the Social Medicine Program at Montefiore Hospital in the Bronx. Dr. Calman has served on many government commissions, including Governor Cuomo's Health Care Advisory Board, and the Pediatric Advisory Committee of the State Department of Health. He is currently the Principal Investigator for a number of research and health services grants including grants from the CDC, NIH, HRSA and many distinguished foundations.

Paul R. Cunningham, M.D.

Professor and Chair, the Department of Surgery at the State University of New York, Upstate Medical University. Dr. Cunningham is also the Program Director for the Surgical Residency within the Department of Surgery. He has held many national leadership positions, including the Chair of the United Network of Organ

Sharing Minority Advisory Affairs Committee (1995-1995); and President of the Eastern Association for the Surgery of Trauma (2000-2001). He is Board Certified in his specialty of General Surgery. He has a current focus in the areas of Trauma and Bariatric Surgery. He has many interests, including Surgical Education, community based prevention initiatives, and the application of computer technologies for the benefit of patient care. Dr. Cunningham has a specific interest in the mentoring and career development of minority students in surgery.

Richard F. Daines, M.D.

Nominated by the Governor to be the fourteenth New York State Health Commissioner on January 18, 2007 and confirmed by the New York State Senate on March 21, 2007. Dr. Daines was the President and CEO of St. Luke's-Roosevelt Hospital Center from January 1, 2002 until January 2007. Previous to joining the Hospital Center as Medical Director in 2000, Dr. Daines served as Senior Vice President for Professional Affairs of St. Barnabas Hospital in the Bronx, New York since 1994 and the Medical Director from 1987 to 1999. Dr. Daines received a Bachelor of History degree from Utah State University in 1974 and served as a missionary for the Church of Jesus Christ of Latter-day Saints in Bolivia, 1970-1972. He received his medical degree from Cornell University Medical College in 1978. He served a residency in internal medicine at New York Hospital and is Board Certified in Internal Medicine and Critical Care Medicine (1987-1997).

Norman H. Edelman, M.D.

Professor in the Departments of Preventive Medicine, Internal Medicine and Physiology and Biophysics at the School of Medicine of Stony Brook University. He served as Vice President for the Health Sciences and Dean of the School of Medicine at Stony Brook from 1996 until June of 2006. Prior to that, he served as Dean of the Robert Wood Johnson Medical School from 1987 through 1995. His major thrust in these positions was the advancement of research and education through development of interdisciplinary programs. His current interest is in the health care workforce supply and demand with focus on the interaction of the various health professions. To that end, he has recently completed a sabbatical year studying health care policy as a visiting professor at the Mailman School of Public Health of Columbia University. Prior to his administrative career he was a respiratory systems physiologist and pulmonary diseases clinician, an interest, which he still maintains.

Walter A. Franck, M.D.

Physician-in-Chief at Bassett Healthcare and Professor of Clinical Medicine/ Associate Dean at Columbia University. He received his M.D. from Columbia in 1964 and post-graduate training in Internal Medicine at the University of Michigan Hospital followed by a clinical and research fellowship in rheumatology at Massachusetts General Hospital, Department of Medicine, and Harvard Medical School. Dr. Franck is certified by the American Board of Internal Medicine in Internal Medicine and Rheumatology. He is a Fellow of The American College of Physicians and American College of Rheumatology. He has been selected by the residents in Medicine as their most valued teacher. His scholarly pursuits focused on gout, arthritis, and other systemic diseases affecting bone and muscle have resulted in over forty publications. After only seven years at Bassett his clinical and administrative contributions were recognized by his appointment as Physician-in-Chief. In addition to research and clinical service, he has also been regularly recognized for his contributions to educational programs by his decade long appointment as Director of Medical Education at Bassett.

Robert M. Glickman, M.D.

Internist and gastroenterologist who is currently the Robert M. and Mary H. Glickman Professor of Medicine and Gastroenterology at the New York University School of Medicine. From 1998-2007, he served as Dean of the NYU School of Medicine and CEO of the NYU Hospitals Center. His past positions included serving as Chief of Gastroenterology at the Columbia Presbyterian Medical Center, the Bard Professor and Chairman of Medicine at Columbia Presbyterian Medical Center (1982-1989), Chairman of Medicine at the Beth Israel Deaconess Medical Center at Harvard Medical School (1989-1998). He has been past presidents of the Association of American Physicians, Association of Professors of Medicine and the American Gastroenterological Association. He is member of the Institute of Medicine of the National Academy of Medicine.

Diane M. Hartmann, M.D.

Associate Dean for Graduate Medical Education at the University of Rochester School of Medicine and Professor of Obstetrics and Gynecology. She is a summa cum laude graduate of Canisius College in Buffalo and received her Doctor of Medicine degree with Honor from the University of Rochester. She completed her residency in Obstetrics and Gynecology at the University of Rochester and is a practicing gynecologist with special expertise in the areas of menopausal and geriatric gynecology. In her current position, Dr. Hartmann is responsible for 75 residency and fellowship programs and over 700 graduate medical trainees at the University of Rochester School of Medicine. Dr. Hartmann is currently a member

of the Board of Directors of the American Board of Obstetrics and Gynecology and serves as an Oral Board Examiner. She is a fellow of the American College of Obstetrics and Gynecology and is the Chair of the Council on Resident Education in Obstetrics and Gynecology (CREOG) for 2008 – 2011. In addition she is a member of the ACGME's Review Committee for Obstetrics and Gynecology.

Robert P. Jacobs M.D., M.B.A.

Consultant with Wellspring Partners, a Huron Consulting Group Practice. Prior to that, he was the Chief Executive Officer and Chief Medical Officer at SUNY Downstate Medical Center. Dr. Jacobs has also served as President and Chief Medical Officer of University MSO at the NYU Medical Center, Regional Medical Director for New York for Oxford Health Plans, Medical Director for the Hospital of the Albert Einstein College of Medicine of Montefiore Medical Center, Vice President for Medical Affairs at Jeanes Hospital in Philadelphia, Professor of Medicine and Chief of the Division of Rheumatology at the George Washington University School of Medicine and a member of the faculty at the Johns Hopkins Schools of Medicine and Public Health. Dr. Jacobs was awarded his MD from the NYU School of Medicine and completed his postgraduate training at Johns Hopkins in Internal Medicine and Rheumatology. He received an MBA from the Wharton School of the University of Pennsylvania.

Edgar Lichstein, M.D.

Chairman of the Department of Medicine at Maimonides Medical Center and has held this position since 1989. Prior to this he was Director of Cardiology also at Maimonides. He holds the rank of Professor of Medicine at the Mount Sinai School of Medicine. Dr. Lichstein's training has all been in New York City. He received his undergraduate degree at Columbia College and then his medical degree at Downstate Medical Center in Brooklyn. His internship was at Lenox Hill Hospital and then his residency and cardiology fellowship at New York University Medical Center. He is Board Certified both in Internal Medicine and Cardiovascular Disease. Dr. Lichstein has been active in research and has published one book, many book chapters and over 150 peer review articles. He has served on the Board of Directors of the New York Heart Association and served as President of the New York Branch of the Association of Program Directors in Internal Medicine.

Mark J. Mundy, F.A.C.H.E.

President and Chief Executive Officer of New York Methodist Hospital, in Park Slope, Brooklyn since 1990. New York Methodist became one of the first hospitals to join a network in 1993 when it joined what is now the New York-Presbyterian

Healthcare System. Previously, he worked for Columbia-HCA as Chief Executive Officer at Quincy Hospital in Massachusetts. Quincy was the first FHA insured public hospital replacement project in the country. Mr. Mundy received a master's degree in hospital administration from Columbia University. He was a captain in the U.S. Army Medical Service Corps – 7th Special Forces Group. He is a member of the board of governors and past chairman of the Greater New York Hospital Association and a member of the board of trustees of the League of Voluntary Hospitals.

Michael F. Noe, M.D., M.P.H., F.A.C.P., F.A.C.P.M., F.A.C.P., C.P.E.

Associate Dean, Community Relations and Clinical Affairs, School of Public Health and Health Professions, University at Buffalo, as well as the Director, General Preventive Medicine Residency Program, Department of Social and Preventive Medicine and Co-Director, Internal Medicine/ Preventive Medicine Combined Residency Program. He is a Diplomate of the National Board of Medical Examiners and is certified by the American Board of Preventive Medicine, the American Board of Internal Medicine, the American Board of Medical Management, and the American College of Physician Executives. He received his MD at SUNY-Upstate, interned at St. Joseph Hospital and Health Center, Syracuse, New York, completed residencies at the U.S. Public Health Service Hospital and Tulane University Medical Center, New Orleans, Louisiana. He has been active with many state associations, including the Buffalo Academy of Medicine, Western New York Health Care Association, Healthcare Association of New York State and the Network in Aging of Western New York.

Harry C. Odabashian, Jr., M.D.

Graduate of Tufts University and attended graduate school at Duke University. He received his medical degree from Albany Medical College in Albany, NY. He completed his internship, residency, and cardiology fellowship at Albany Medical Center Hospital. He is Board Certified in Internal Medicine and Cardiovascular Diseases. He is a Fellow of the American College of Cardiology, and a Fellow of the Society of Cardiac Angiography. He has been Chief of Cardiology and Director of the Cardiac Catheterization Laboratory at St. Peter's Hospital in Albany, NY. He is a Clinical Assistant Professor of Medicine at Albany Medical College. He received the American Heart Association's Hearts of Gold Award in 1998. He is currently the upstate Governor of the American College of Cardiology, the President of the New York Cardiological Society, and the President elect of the New York State Chapter of the American College of Cardiology.

Herbert Pardes, M.D.

President and CEO of New York-Presbyterian Hospital and New York-Presbyterian Healthcare System. Nationally recognized for his broad expertise in education, research, clinical care and health policy, Dr. Pardes is an ardent advocate of support for academic medical centers, humanistic care and the power of technology and innovation to transform 21st-century medicine. A noted psychiatrist, Dr. Pardes served as Director of the National Institute of Mental Health (NIMH) and U.S. Assistant Surgeon General during the Carter and Reagan Administrations. He was also President of the American Psychiatric Association. In 1984, he was named Chairman of the Department of Psychiatry at Columbia University College of Physicians and Surgeons, and in 1989, was appointed Vice President for Health Sciences for Columbia University and Dean of the Faculty of Medicine at Columbia University College of Physicians and Surgeons. In 1999, Dr. Pardes was chosen to lead New York-Presbyterian. He has been appointed to serve on commissions related to health policy by Presidents Bush and Clinton and negotiated and conducted international collaborations with a variety of countries including India, China and the former Soviet Union. Dr. Pardes has earned numerous awards and accolades.

Barbara Ross-Lee, D.O., F.A.C.O.F.P.

Vice President for Health Sciences and Medical Affairs New York Institute of Technology. She also served as Dean of the School of Allied Health and Life Sciences and Dean of the New York College of Osteopathic Medicine and dean of the Ohio University College of Osteopathic Medicine (OUCOM), the chairperson of the Department of Family Medicine at Michigan State University College of Osteopathic Medicine, and Associate Dean for Health Policy at the Michigan State University College of Osteopathic Medicine. She holds a Doctor of Osteopathic Medicine degree from Michigan State University. She is the first African-American female to serve as dean of a United States medical school. She was the first osteopathic physician to participate in the Robert Wood Johnson Health Policy Fellowship and served as legislative assistant for health to Senator Bill Bradley. She ran a solo family practice in Detroit prior to pursuing an academic medicine career. She is a Fellow of the American Osteopathic Board of Family Physicians. She has lectured widely, and published numerous scholarly articles on a variety of medical and health-care issues. Dr. Ross-Lee is the past Chair of the AOA's Minority Health Initiative and past member of the NIH Advisory Committee on Research on Women's Health and the NIH Advisory Committee on Rural Health. She has received five honorary degrees.

Alan R. Roth, D.O., F.A.A.F.P.

Chairman, Department of Family Medicine, Ambulatory Care and Community Medicine. Program Director, Family Medicine Residency Program, Chief, Division of Palliative Care Medicine, and Program Director, Palliative Care Fellowship, at Jamaica Hospital Medical Center. He is also an Assistant Professor of Community and Preventive Medicine, Mt. Sinai School of Medicine and Family Medicine at the New York College of Osteopathic Medicine. Dr. Roth is a dually certified Diplomate of the American Board of Family Medicine. He is also Board Certified in Hospice and Palliative Medicine. Dr. Roth's primary goal is to develop and enrich the training experiences of physicians interested in urban Family Medicine and Palliative Care. He has completed a Residency Program Director Fellowship with the American Academy of Family Physicians and lectures nationally on urban Family Medicine Residency training, Palliative Care and curriculum development. His special areas of interest include cultural competency training in graduate medical education, palliative medicine, disease prevention, health promotion and procedural skills. Dr. Roth has been honored with numerous award including NY Magazines' Best Doctor, Best Family Doctors in America and Association of Family Medicine Residency Directors Gold Level Award.

Vicki L. Seltzer, M.D.

Vice President for Women's Health Services of the North Shore-Long Island Jewish Health System, which provides obstetrical care for more than 20,000 women at 7 hospitals. She is the Chair of the Departments of Obstetrics and Gynecology at both the North Shore University Hospital and the Long Island Jewish Medical Center. Dr. Seltzer previously served as President of the American College of Obstetricians and Gynecologists, the organization representing the more than 40,000 Ob-Gyns in the United States dedicated to improving the health of women. She was also President of the New York Obstetrical Society. Dr. Seltzer is the editor of the textbook, Women's Primary Health Care. She is also author of the book, Every Woman's Guide to Breast Cancer, Founding Editor-in-Chief of the medical journal, Primary Care Update for Ob/Gyns for which she was Editor-in-Chief for ten years, and the author of more than 100 medical articles and textbook chapters. Dr. Seltzer has served important roles in many national and international medical organizations including the International Federation of Gynecology and Obstetrics, the Obstetrics and Gynecology Residency Review Committee, the National Council on Graduate Medical Education, and the Council on Resident Education in Obstetrics and Gynecology (which she chaired for six years). Dr. Seltzer was one of the first women in the United States to be board certified as a subspecialist in gynecologic oncology.

Alwin Steinmann, M.D.

Received his MD degree from the New York University School of Medicine and completed his internal medicine residency at the Albany Medical Center. He then joined the full-time faculty in the Division of General Internal Medicine at Albany Medical College where his duties included provision of primary care to adult patients and the teaching of residents and medical students. Dr. Steinmann is currently an Associate Professor of Medicine, Program Director of the Internal Medicine Residency Training Program and Vice-Chair for Academic Affairs in the Department of Medicine. A long-standing member of the New York Chapter of the ACP (Hudson Valley Region), he has served on the chapter Council and currently chairs the Health and Public Policy Committee. He has chaired the planning committee of two statewide ACP Health and Public Policy Meetings. He has been an active member of the Association of Program Directors in Internal Medicine (APDIM) since becoming program director in 1997 and is a past president of the APDIM New York Special Interest Group. He also serves on the national APDIM Public Policy Committee, currently as the Chair.

Steven E. Szebenyi, M.D., M.M.M.

Executive Director of Foundation for Healthy Living, a non-profit, 501(c) 3, health services and research foundation. A graduate of Johns Hopkins School of Medicine and the University of Southern California Marshall School of Business, Dr. Szebenyi is a board certified internist with more than 25 years of clinical research and management experience. Dr. Szebenyi spent ten years as a practicing primary care physician before becoming the Head of the Division of HIV Medicine at Albany Medical College at the forefront of the AIDS epidemic. An interest in research led the way to his role as Principal Investigator on more than \$25 million in clinical and non-clinical research grants and programs. Dr. Szebenyi rounded out his health care experience by becoming Medical Director for BlueShield of Northeastern New York, where he played a major leadership role in implementing collaborative projects with regional health plans and led BlueShield to consistently “Excellent” ratings by NCQA. In addition to the Foundation for Healthy Living, Dr. Szebenyi is also: Clinical Professor of Medicine at Albany Medical College, Clinical Professor in the Department of Health Policy, Management and Behavior at the SUNY Albany School of Public Health.

Miriam T. Vincent, M.D., Ph.D.

Professor and Chair, and, Director of Faculty Development at SUNY-Downstate Medical Center in the Department of Family Medicine. She received her MD degree from SUNY-Downstate School of Medicine in 1985 and her PhD from SUNY-Downstate Medical Center in Cellular and Molecular Biology in 2004. She

completed her residency training and Chief Residency at KCH/UHB SUNY Downstate Center in 1988 and is Board Certified in Family Practice since 1988. She is Chair of the Education Commission of the New York State Academy of Family Physicians since 2006 and President of the Kings County Academy of Family Physicians since 1999. Her basic science thesis and research efforts advanced the novel concept that islet cell hormones were involved in a feedback mechanism to the pancreas to affect islet cell growth, differentiation and function, now a key concept in our understanding of Diabetes mellitus. She has received many awards.



New York State
David A. Paterson, Governor